STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4000	A. BUILDING _____ B. WING _____	08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAS VENTANAS RETIREMENT COMMUNITY	10401 WEST CHARLESTON BLVD, 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 an annual State Licensure survey completed at your facility on 08/01/23, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 76 Residential Facility for Group beds for elderly and disabled persons, assisted living services, and/or persons with Alzheimer's disease, and/or persons with intellectual disability, Category II residents. The census at the time of the survey was 51. 15 resident files and ten employee files were reviewed. The facility received a grade of C. 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 regulatory deficiencies were identified:	0000		
0220 SS= F	Laundry & Linen Services Provided - NAC 449.213 Laundry and linen services. (NRS 449.0302) 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 services 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 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.	0220	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law* The Dryer located in the laundry room on the first-floor exhaust hose had become	08/23/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4000	A. BUILDING _____ B. WING _____	08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAS VENTANAS RETIREMENT COMMUNITY	10401 WEST CHARLESTON BLVD, 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
	Inspector Comments: Based on observation and interview, the facility failed to ensure a dryer was properly ventilated to the outside of the building. Findings include: On 08/01/23 at 9:15 AM, the laundry room located on the first floor had lint on the back of the dryer and on the wall. The exhaust hose leading from the dryer to the wall was not connected to the wall allowing it to vent directly into the laundry room. On 08/01/23 at 9:15 AM, the Maintenance Director acknowledged the laundry area needed to be cleaned and the exhaust hose needed to be attached to the wall. Severity: 2 Scope: 3		detached from the wall. During the survey on 08/01/23. The maintenance director connected the hose to the outside vent and had all lent cleaned from the backside of the dryer and the surrounding area. The maintenance staff then checked all other dyers and all had the exhaust hoses connected to the outside with no lent issues. Regular rounds by the Maintenance Director have been made of these areas to ensure that immediate compliance occurred and maintained. Environmental Service staff are being re-educated on the policy and procedures around the checking daily for proper ventilation of all dryers and checking for presence of lint. Any issues or non-compliance with ventilation or lint accumulation will be corrected immediately and reported to the administrator for follow-up. Responsible Person/designee: Plant Operation Director	
0255 SS= F	Permits-Comply with NAC 446 on Food Service - NAC 449.217 Kitchens; storage of food; adequate supplies of food; permits;	0255	*Y0255*	08/23/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4000	A. BUILDING _____ B. WING _____	08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAS VENTANAS RETIREMENT COMMUNITY	10401 WEST CHARLESTON BLVD, 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
	inspections. (NRS 449.0302) 6. A residential facility with more than 10 residents shall: (a) Comply with the standards prescribed in chapter 446 of NAC; and (b) Obtain the necessary permits from the Division. Inspector Comments: Based on observation on 08/01/2023, the facility failed to ensure the kitchen and supportive dining services complied with the standards of NAC 446. Findings include: 1. Critical Violations: a. In the walk-in cooler, a carton of liquid eggs was expired 07/12/23 and multiple cartons of coconut milk were expired 07/27/23. In the country kitchen freezer, cookie dough was expired 07/06/23. b. In the walk-in cooler, pot roast was cooked on 07/31/23; however, the pot roast was not cooled properly and was between 48 to 53 degrees Fahrenheit (F). 2. Major Violations: a. An ice cream scoop was stored, on top of the ice cream freezer, in a container of water at 70 degrees F for bulk ice cream dispensing. Severity: 2 Scope: 3		*What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:* There were no specific residents cited in the findings. The following items cited in the findings were removed from the walk-in cooler on 8/1/23 and discarded: The carton of expired liquid Eggs Multiple cartons of expired Coconut Milk The Pot Roast that was not cooled correctly The expired Cookie dough, identified in the findings, found in the country kitchen freezer was removed on 8/1/23 and discarded by the Director of Dining Services. The ice cream scoop found in a container of water at 70 degrees Fahrenheit, was removed on 8/1/23 and sanitized per our policy prior to use. *How will you identify other residents having the potential to be affected by the same practice and what anticipated corrective action will be taken:* All residents have the potential to be affected by this practice. The Director of Dining Services or designee is conducting daily inspections of the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4000	A. BUILDING _____ B. WING _____	08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAS VENTANAS RETIREMENT COMMUNITY	10401 WEST CHARLESTON BLVD, 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
			kitchen and all service areas. This includes the walk-in cooler and all refrigerator /freezers storing any food items to ensure that no items are expired and that any items being cooled are being done so per policy. It also includes checking scoops used for serving ice cream are stored per policy/regulation and industry standards. Any non-compliance will be corrected immediately. *What measures will be put into place or what systemic changes will you make to ensure the deficient practice does not recur:* Kitchen and service staff are being re-educated by the Director of Dining Services/designee on the policy and procedure for food storage including ensuring that expired food is not stored with food items in the coolers/refrigerators or freezers. The cooling procedures for any cooked items and the proper documentation required on the cooling log was also covered. The proper use and storage of ice cream scoops is part of this education. Education was completed on 8/16/23 *How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:* The Director of Dining Services or designee will continue to conduct daily inspections of the kitchen and all service areas. This includes the walk-in cooler and all refrigerator /freezers storing any food items to ensure that no items are expired and that any items being cooled are being done so per policy. It also includes checking scoops used for serving ice cream are stored per policy/regulation and industry standards. Any non-compliance will be corrected immediately.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4000	A. BUILDING _____ B. WING _____	08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAS VENTANAS RETIREMENT COMMUNITY	10401 WEST CHARLESTON BLVD, 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
			Any non-compliance will be reported to the Administrator and corrected immediately. *Responsible person :* Dining Services Director	
0870 SS= D	Medication Administration-Accuracy & Report - NAC 449.2742 Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall: (a) Ensure that a physician, pharmacist or registered nurse who does not have a financial interest in the facility: (1) Reviews for accuracy and appropriateness, at least once every 6 months the regimen of drugs taken by each resident of the facility, including, without limitation, any over-the-counter medications and dietary supplements taken by a resident; and (2) Provides a written report of that review to the administrator of the facility. (b) Include a copy of each report submitted to the administrator pursuant to paragraph (a) in the file maintained pursuant to NAC	0870	*What corrective actions will be accomplished for those residents found o have been affected by the deficient practice:* Regarding Resident #11, the consulting Pharmacist completed a medication review on 08/01/23 which was signed by the physician and filed in this residents file. This resident is scheduled for a new medication review in the next 6 months. Regarding Resident #13, the consulting Pharmacist completed a medication review on 08/01/23 which was signed by the physician and filed in this residents file. This resident is scheduled for a new medication review in the next 6 months.	09/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4000	A. BUILDING _____ B. WING _____	08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAS VENTANAS RETIREMENT COMMUNITY	10401 WEST CHARLESTON BLVD, 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
	449.2749 for the resident who is the subject of the report. (c) Make and maintain a report of any actions that are taken by the caregivers employed by the facility in response to a report submitted pursuant to paragraph (a). Inspector Comments: Based on interview and record review, the facility failed to ensure a medication review was completed every six months for 2 of 15 sampled residents (Resident #11 and #13). Findings include: Resident #11 (R11) Resident #11 was admitted on 11/26/21 with diagnoses of hypertension and gastroesophageal reflux disease (GERD). R11's file lacked documented evidence a medication review was completed every six months. Resident #13 (R13) Resident #13 was admitted on 06/14/22 with diagnoses of hypertension and diabetes mellitus. R13's file lacked documented evidence a medication review was completed every six months. On 08/01/23 at 1:45 PM, the Administrator acknowledged R11 and R13's file lacked documented evidence a medication review was completed every six months. Severity: 2 Scope: 1		*How will you identify other residents having the potential to be affected by the same practice and what anticipated corrective action will be taken:* All residents have the potential to be affected by this practice. A 100% audit is being completed of all current Resident medical records on 9/7/23 for all state required documentation including a medication review and follow up as required at least every 6 months per regulation. *What measures will be put into place or what systemic changes will you make to ensure the deficient practice does not recur:* The Wellness Director/ AL manager were re-educated by the administrator on 8/1/23on the necessity of ensuring that medication reviews are completed at least every6 months and filed in the resident file. *How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:* The Wellness Director or designee will complete an on-going quarterly audit to ensure that medication reviews are completed buy the consulting pharmacist with any necessary follow-up at least every 6 months and available in the residents file. Any non-compliance will be reported immediately to the Administrator and corrected immediately.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4000	A. BUILDING _____ B. WING _____	08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAS VENTANAS RETIREMENT COMMUNITY	10401 WEST CHARLESTON BLVD, 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
			Responsible Person : Wellness Director *Completion Date:* 9/7/2023	
0876 SS= D	Medication Administration - NRS 449.0302 - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 4. Except as otherwise provided in this subsection, a caregiver shall assist in the administration of medication to a resident if the resident needs the caregiver's assistance. A caregiver may assist the ultimate user of: (a) Controlled substances or dangerous drugs only if the conditions prescribed in subsection 6 of NRS 449.0302 are met. (b) Insulin using an auto-injection device only if the conditions prescribed in NRS 449.0304 and NAC 449.1985 are met. Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 15 sampled residents had a signed Ultimate User Agreement (Resident #5). Findings include: Resident #5 (R5) R5 was admitted on 11/04/22 with diagnoses including hypertension and recurrent fall and vertigo. R5's file lacked documented evidence of an Ultimate User agreement signed by R5 or R5's representative allowing for medication administration by the facility. On 08/01/23, the Administrator acknowledged R5 was missing a signed Ultimate User Agreement and was unable	0876	*What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:* A new Ultimate User Agreement was signed by Resident #5 on 8/2/2023 and filed correctly in his medical record. *How will you identify other residents having the potential to be affected by the same practice and what anticipated corrective action will be taken:* All residents have the potential to be affected by this practice. A 100% audit is being completed of all current Resident medical records on 9/7/23 for all state required documentation including Ultimate User Agreements . *What measures will be put into place or what systemic changes will you make to ensure the deficient practice does not recur:*	09/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4000	A. BUILDING _____ B. WING _____	08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAS VENTANAS RETIREMENT COMMUNITY	10401 WEST CHARLESTON BLVD, 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
	to provide documented evidence. Severity: 2 Scope: 1		The Wellness Director/ AL manager by the administrator on the necessity of ensuring the Ultimate user Agreement is signed and available in the Residents Medical Record on 8/2/23 *How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:* The Wellness Director or designee will complete an audit at the time of admission and on-going to ensure an Ultimate is signed and in the medical record. Any non-compliance will be reported immediately to the Administrator and corrected immediately. *Responsible Person :* Wellness Director *Completion Date:* 9/7/2023	
0936 SS= D	Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be	0936	*What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:*	09/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4000	A. BUILDING _____ B. WING _____	08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAS VENTANAS RETIREMENT COMMUNITY	10401 WEST CHARLESTON BLVD, 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
	maintained for each resident of a residential facility and retained for at least 5 years after he or she permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including, without limitation: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. Inspector Comments: Based on interview and record review, the facility failed to ensure 2 of 10 sampled residents met the requirements for tuberculosis (TB) testing in accordance with Nevada Administrative Code (NAC) 441A (Resident #8 and #9). Findings include: Resident #8 (R8) R8 was admitted to the facility on 05/31/23 with diagnoses including cerebral infarction and hypertension. R8 completed the first-step TB test on 03/22/23. R8's file lacked documented evidence of a completed second-step TB test. Resident #9 (R9) R9 was admitted to the facility on 04/20/23 with diagnoses including Alzheimer's disease and hypertension. R9 completed the first-step TB test on 04/16/23. R9's file lacked documented evidence of a completed second-step TB test. On 08/01/23 at 1:45 PM, the Administrator acknowledged Resident #8 and #9's files lacked documented evidence of the second step of an initial two-step tuberculosis (TB) test in accordance with Nevada Administrative Code (NAC) 441A. Severity 2 Scope 1		Regarding Resident #8, a new 2 step TB test is being completed on this resident. Regarding Resident #9, , a new 2 step TB test is being completed on this resident. *How will you identify other residents having the potential to be affected by the same practice and what anticipated corrective action will be taken:* All residents have the potential to be affected by this practice. A 100% audit is being completed of all current Resident medical records by 9/7/23 for all state required documentation including an initial 2 step PPD or Tuberculosis test per regulation. *What measures will be put into place or what systemic changes will you make to ensure the deficient practice does not recur:* The Wellness Director/ AL manager were re-educated by the administrator on 8/1/23on the necessity of ensuring that Tuberculosis testing is completed initially and then annually per the regulation and that these must be available in the residents file. medication reviews are completed at least every 6 months and filed in the resident file. *How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:* The Wellness Director or designee will complete an on-going audit of each new	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4000	A. BUILDING _____ B. WING _____	08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAS VENTANAS RETIREMENT COMMUNITY	10401 WEST CHARLESTON BLVD, 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
			move-in and then annually to ensure that the state required documentation including an initial 2 step PPD or Tuberculosis test per regulation is conducted. and then the annual Tuberculosis testing is also completed per regulation.. Any non-compliance will be reported immediately to the Administrator and corrected immediately. *Responsible Person :* Wellness Director *Completion Date:* 9/7/2023	
0938 SS= D	Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he or she permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including, without limitation: (g) An evaluation of the resident ' s ability to perform the activities of daily living and a brief description of any assistance he or she needs to perform those activities. The facility shall prepare	0938	*What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:* Regarding Resident #1, a new ADL assessment was completed on08/18/2023. Regarding Resident #7. an ADL assessment was completed on 06/26/2023. It was reviewed on 8/17/2023 and reflects her current condition. An annual is scheduled to be completed unless she has a change in condition.	09/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4000	A. BUILDING _____ B. WING _____	08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAS VENTANAS RETIREMENT COMMUNITY	10401 WEST CHARLESTON BLVD, 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
	such an evaluation: (1) Upon the admission of the resident; (2) Each time there is a change in the mental or physical condition of the resident that may significantly affect his or her ability to perform the activities of daily living; and (3) In any event, not less than once each year. Inspector Comments: Based on interview and record review, the facility failed to ensure an Activities of Daily Living (ADL's) Assessment was completed upon admission for 1 of 10 sampled residents (Resident #1) and annually for 1 of 10 sampled residents (Resident #7). Findings include: Resident #1 (R1) R1 was admitted on 12/20/22 with diagnoses including vascular dementia and hypertension. R1's file lacked documented evidence an ADL's assessment was completed at admission. Resident #7 (R7) R7 was admitted to the facility on 05/10/14 with diagnoses including glaucoma, hearing loss, and hypertension. R7's file lacked documented evidence of an annual ADL's assessment for 2023, with the last ADL's assessment completed on 05/10/22. On 08/01/23 at 1:45 PM, the Administrator acknowledged R1's file lacked documented evidence of an initial ADL's assessment and R7's file lacked documented evidence of an annual ADL's assessment. Severity: 2 Scope: 1		*How will you identify other residents having the potential to be affected by the same practice and what anticipated corrective action will be taken:* All residents have the potential to be affected by this practice. A 100% audit is being completed of all current Resident medical records by 9/7/23 including the required ADL assessments to be completed upon move-in and annually or when a change of condition occurs. *What measures will be put into place or what systemic changes will you make to ensure the deficient practice does not recur:* The Wellness Director/ AL manager were re-educated by the administrator on 8/1/23on the necessity of ensuring that ADL assessments are completed and in the file per regulation. *How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:* The Wellness Director or designee will complete an on-going audit of each new move-in and then annually to ensure that the state required documentation including that ADL assessments are completed and in the file per regulation. Any non-compliance will be reported immediately to the Administrator and corrected immediately.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4000	A. BUILDING _____ B. WING _____	08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAS VENTANAS RETIREMENT COMMUNITY	10401 WEST CHARLESTON BLVD, 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
			Responsible Person : Wellness Director *Completion Date:* 9/7/2023	
0991 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 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 shall ensure that: (b) Operational alarms, buzzers, horns or other audible devices which are activated when a door is opened are installed on all doors that may be used to exit the facility. Inspector Comments: Based on observation and interview, the facility failed to ensure a door leading to the outside courtyard of the memory care unit was equipped with a functional audible alarm. Findings include: On 08/01/2023 at 9:30 AM, when exiting the the memory care unit through the door leading to the outside courtyard, the alarm did not make an audible sound. When coming back in to the memory care unit through the same door, the alarm did not make an audible sound. On 08/01/2023 at 9:30 AM, the Maintenance Director confirmed the alarm did not make an audible sound when exiting or entering the courtyard. Severity: 2 Scope: 3	0991	*What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:* There were no specific residents cited in the findings. The Closed courtyard door that was found with the alarm shut-off was turned on during the state survey on 08/01/2023 by the Maintenance Director. *How will you identify other residents having the potential to be affected by the same practice and what anticipated corrective action will be taken:* All residents have the potential to be affected by this practice. The Memory Care Manager and the Maintenance/Staff are conducting daily inspections to ensure the alarm is on and functioning correctly. Any non-compliance	08/21/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4000	A. BUILDING _____ B. WING _____	08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAS VENTANAS RETIREMENT COMMUNITY	10401 WEST CHARLESTON BLVD, 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
			will be corrected immediately. *What measures will be put into place or what systemic changes will you make to ensure the deficient practice does not recur:* All Memory Care staff are being re-educated Memory Care Manager on the necessity of ensuring that the alarm is always on and functional. Education was completed on 8/21/23. *How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:* The Memory Care Manager and the Maintenance/Staff will continue to conduct daily inspections to ensure the alarm is on and functioning correctly. Any non-compliance will be corrected immediately and reported to the Administrator and corrected immediately. Persons Responsible: Memory Care Manager	
1006 SS= E	Adults with Intellectual Disabilities - NAC 449.2762 Residential facility which offers or provides care for adults with intellectual disabilities or adults with related conditions: Application for endorsement; training for caregivers. (NRS 449.0302) 2. Within 60 days after being employed by a residential facility for adults with intellectual disabilities, a caregiver must receive not less than 4 hours of training related to the care of persons with intellectual disabilities.	1006	*What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:* Regarding Team Member # 1, this team member has completed the required 4	09/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4000	A. BUILDING _____ B. WING _____	08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAS VENTANAS RETIREMENT COMMUNITY	10401 WEST CHARLESTON BLVD, 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
	Inspector Comments: Based on record review and interview, the facility failed to ensure 3 of 10 employees completed four hours of training related to care of persons with intellectual disabilities within 60 days of hire (Employee #1, Employee #3 and Employee #4). Employee #1 was hired on 03/07/23, Employee #3 was hired on 02/21/23 and Employee #4 was hired on 02/21/23. There was no documented evidence Intellectual Disability training was completed for Employee #1, Employee #3 or Employee #4 within 60 days of hire. The Administrator confirmed Employee #1, Employee #3 and Employee #4 did not complete four hours of Intellectual Disability training within 60 days of hire. Severity: 2 Scope: 2		hours of training related to the care of persons with intellectual disabilities on 08/14/2023. Regarding Team Member # 3, this team member has completed the required 4 hours of training related to the care of persons with intellectual disabilities on 08/18//2023. Regarding Team Member #4, this team member has completed the required 4 hours of training related to the care of persons with intellectual disabilities on 08/16//2023. *How will you identify other residents havingthe potential to be affected by the same practice and what anticipatedcorrective action will be taken:* All residents with Intellectual disabilities or related conditions have the potential to be affected by this practice. A 100% audit is being completed of all current Team Member files to ensure that all required training/education, including the initial 4 hours of training related to the care of persons with intellectual disabilities is completed. Any non-compliance will be corrected immediately. *What measures will be put into place or what systemic changes will you make to ensure the deficient practice does not recur:* The Administrator has reviewed with HR the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4000	A. BUILDING _____ B. WING _____	08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAS VENTANAS RETIREMENT COMMUNITY	10401 WEST CHARLESTON BLVD, 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
			training requirements for all staff including the initial 4 hours of training related to the care of persons with intellectual disabilities within 60 days of hire on 8/2/23. *How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:* The HR Director or designee will complete an audit at the time of hire and on-going for the first 90 days and yearly thereafter to ensure that all required training/education is completed by the team member in the required timeframes. This includes the initial training related to persons with intellectual disabilities in the first 60 days of employment. Any non-compliance will be reported to the Administrator and corrected immediately. *Responsible person :* Administrator *Completion Date:* 9/07/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4000	A. BUILDING _____ B. WING _____	08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAS VENTANAS RETIREMENT COMMUNITY	10401 WEST CHARLESTON BLVD, 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