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 _____	07/02/2025

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

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure survey completed in your facility on 07/02/25, 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 52. 15 resident files and ten employee files were reviewed. The facility received a grade of A. 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		
0074 SS= E	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 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	0074	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. *What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:* • As of 7/21/25, Team Members #6, and #9 have completed the required annual Elder Abuse Prevention and Reporting training. Team Member #4 has been taken off the schedule until it is completed. Team Member #8 is a Per diem who has not been actively working, they will not be	08/01/2025

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	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 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		allowed to work unless training is completed. Proof of completion for TM #6 and #9 is attached and placed in each of their file. *How will you identify other residents having the potential to be affected by the same practice and what anticipated corrective action will be taken:* An on-going audit of all staff files was completed by the HR Director/Designee on 07/09/25, any non-compliance is addressed immediately, reported to the Administrator. On-going compliance is a condition of continued employment. The new HR director has reviewed the Regulations and was educated on the requirements by 7/18/25. • *What measures will be put into place or what systemic changes will you make to ensure the deficient practice does not recur:* • Staff Training covering changes in the training system will be completed by the Administrator/Wellness Director on 7/25/25. • In the past, annual Abuse Training has been on Relias and is self-paced for the student but is to be completed by the due date. Effective immediately, Mandatory In person training will be done quarterly for those approaching their due date and is a condition for their continued employment. Annual Mandatory Training will occur every February,	

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	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 pursuant to NRS 449.160 and 449.163. Inspector Comments: Based on record review and interview, the facility failed to ensure 4 of 10 sampled employees had completed annual elder abuse training (Employee #4, #6, #8 and #9). Findings include: Employee #4 (E4) E4 was hired on 06/24/24 as a Resident Assistant. E4 completed initial elder abuse training on 06/28/24. E4's file lacked documented evidence of annual elder abuse training. Employee #6 (E6) E6 was hired on 02/27/24 as a Medication Technician. E6 completed initial elder abuse training on 02/27/24. E6's file lacked documented evidence of annual elder abuse training. Employee #8 (E8) E8 was hired on 06/15/24 as a Medication Technician. E8 completed initial elder abuse training on 06/20/24. E8's file lacked documented evidence of annual elder abuse training. Employee #9 (E9) E9 was hired on		with Quarterly sessions available for compliance. *How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:* • The Administrator or designee will conduct **monthly audits** of staff training records to ensure documentation of annual Elder Abuse training is present and current. • Results of audits will be documented and reviewed during monthly Quality Assurance and Performance Improvement Meetings (QAPI) meetings for at least the next 3 months to verify compliance and assess any need to alter this plan. *Responsible person, designee: Administrator* *Completion Date: 8/01/25*	

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	07/28/23 as a Certified Nursing Assistant. E9 completed annual elder abuse training on 03/19/24. E9's file lacked documented evidence of annual elder abuse training. On 07/02/25 in the morning, the Director of Human Resources acknowledged the missing annual elder abuse trainings and reported the training was not completed. Severity: 2 Scope: 2			
0102 SS= D	Personnel File - TB Screening - NAC 449.200 Personnel files. 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (d) The health certificates required pursuant to chapter 441A of NAC for the employee; Inspector Comments: Based on interview and record review, the facility failed to ensure an annual tuberculosis (TB) test was completed for 2 of 10 employees (Employee #6 and #8). Findings include: Employee #6 (E6) E6 was hired on 02/27/24, as a Medication Technician. E6's file revealed a two-step TB test completed on 08/03/23. E6's file lacked documented evidence of an annual TB test for 2024 and 2025. Employee #8 (E8) E8 was hired on 06/15/24, as a Medication Technician. E8's file revealed a QuantiFERON test completed on 04/11/24. E8's file lacked documented evidence of an annual TB test for 2025. On 07/02/25 in the morning, the Director of Human Resources acknowledged the missing documentation and was unable to provide the annual TB tests. Severity: 2 Scope: 1	0102	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. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: Team Members #6, completed the questionnaire required on 7/18/25, and we have copies of the (+) PPD and negative chest x-ray #8 employment was terminated on 08/01/25. Proof of completion for Team Member #6 is attached and is placed in their file. How will you identify other residents having the potential to be affected by the same practice and what anticipated corrective action will be taken: An on-going audit of all staff files was completed by the HR Director/Designee on 07/09/25. The new HR director has reviewed the regulations and was educated on the requirements by 7/18/2025., any non-compliance is addressed immediately, reported to the Administrator. On-going compliance is a condition of continued employment. What measures will be put into place or what systemic changes will you make to ensure the deficient practice does not recur: Staff Training covering changes in the tracking system and making timely completion of their TB screening, per	08/01/2025

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			regulation, a condition of their employment, will be completed by the Administrator/Wellness Director on 7/25/25. In the past, annual TB testing was reliant on the Team Member being compliant, having the TB test done on or prior to their anniversary will be a condition of employment. HR will continue the on-going audit for Annual TB tests /screenings and staff will receive a 3o day notice that the TB test is due to ensure timely completion. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The Administrator or designee will conduct monthly audits of resident files to ensure TB records are up to date. Any overdue TB tests will result in removal from duty until compliance is met. Results of audits will be documented and reviewed during monthly Quality Assurance and Performance Improvement Meetings (QAPI) meetings for at least the next 3 months to verify compliance and assess any need to alter this plan. Responsible person, designee: Administrator Completion Date: 8/01/25	
0106 SS= D	Personnel File - 1st Aid & CPR - NAC 449.200 Personnel files 2. The personnel file for a caregiver of a residential facility must include, in addition to the information required pursuant to subsection 1: (a) A certificate stating that the caregiver is currently certified to perform first aid and cardiopulmonary resuscitation; Inspector Comments: Based on record review and interview, the facility failed to ensure 2 of 10 employees received in person cardiopulmonary resuscitation (CPR) training. (Employee #1 and #4) Findings include: Employee #1 (E1) E1 was hired on 10/03/17 as a Certified Nursing Assistant. E1's file revealed CPR training was completed online on 04/01/25. E1's record lacked documented evidence of the	0106	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. *What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:* • As of 7/21/25, Team Members #1,	08/01/2025

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	CPR in person component. Employee #4 (E4) E4 was hired on 06/24/24 as a Resident Assistant. E4's file revealed CPR training was completed online on 06/28/24. E4's record lacked documented evidence of the CPR in person component. On 07/02/25 in the morning, the Director of Human Resources confirmed the online CPR training did not have the in person component for E1 and E4. The Director of Human Resources verbalized being unaware the in person component was required to be in compliance. Severity: 2 Scope: 1		and #4 have been taken off the schedule until they complete the approved in-person CPR course. Proof of successful completion for TM #1 and #4 will be received prior to being scheduled. *How will you identify other residents having the potential to be affected by the same practice and what anticipated corrective action will be taken:* An on-going audit of all staff files was completed by the HR Director/Designee on 07/09/25. The new H Director has reviewed the regulations and was educated on the requirements. Any non-compliance with in-person approved CPR courses will be immediately addressed and reported to the Administrator. On-going compliance is a condition of continued employment. • *What measures will be put into place or what systemic changes will you make to ensure the deficient practice does not recur:* • Staff Training covering changes in the compliance to the First Aid/ CPR training system will be completed by the Administrator/Wellness Director on 7/25/25. • In the past, annual CPR Training has been reliant on Team Members compliance. An In-person class is offered every 60 days on site and is mandatory every two years. Mandatory In person training will be done every 60 days for those approaching their due date and is a condition for their continued employment. Annual Mandatory	

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			Training will occur every February, with Quarterly sessions available for compliance. *How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:* • The Administrator or designee will conduct **monthly audits** of staff personnel records to ensure documentation of current in-person CPR certification is present. • Results of audits will be documented and reviewed during monthly Quality Assurance and Performance Improvement Meetings (QAPI) meetings for at least the next 3 months to verify compliance and assess any need to alter this plan. *Responsible person, designee: Administrator* *Completion Date: 8/01/25*	
0620 SS= D	Written Policy on Admissions - NAC 449.2702 and R043-22 Written policy on admissions; eligibility for residency. (NRS 449.0302) 4. Except as otherwise provided in NAC 449.275, a residential facility shall not admit or allow to remain in the facility any person who: (a) Is bedfast; (b) Requires restraint; (c) Requires confinement in locked quarters; or (d) Requires skilled nursing or	0620	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	08/01/2025

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	other medical supervision on a 24-hour basis. Inspector Comments: Based on observation, interview and record review, the facility failed to obtain a medical exemption to maintain a resident who has a Foley catheter for 1 of 15 residents (Resident #1). Findings include: Resident #1 (R1) R1 was admitted to the facility on 05/15/2025 with diagnoses including macular degeneration and failure to thrive. On 07/02/2025 in the afternoon, R1 was observed alert and eating in the dining room with the other residents. On 07/02/2025 in the afternoon, R1 was interviewed in their resident room. R1 was able to demonstrate their ability to empty their own Foley catheter bag without assistance. R1 shared they tried to do as much as they could on their own when it involved their activities of daily care and living. R1 indicated the visiting nurse would assist with the Foley catheter maintenance. On 07/02/2025 in the afternoon, Employee #3 (E3) verified R1 could not perform the regular maintenance to flush the Foley catheter tubing or to replace the Foley catheter bag even with assistance. E3 explained the visiting nurse from the hospice agency would perform the Foley Catheter maintenance which was documented during the development of R1's Plan of Care. On 07/02/2025 in the afternoon, R1's record lacked documented evidence of an approved medical exemption or a submission to the Bureau for one for R1. On 07/02/2025 in the afternoon during the exit, E3 had confirmed with the Administrator the facility did not have an approved medical exemption or submit a medical exemption application to retain R1 with a Foley catheter. Severity: 2 Scope: 1		solely because it is required by the provisions of federal and state law. *What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:* • As of 7/21/25, Resident #1 has a request in to HCQC for an exemption. This resident is able to provide the daily care of her catheter but has home Health following her to change the bag, monitor etc. Confirmation of Home health services was documented and is incorporated into the Care Plan. *How will you identify other residents having the potential to be affected by the same practice and what anticipated corrective action will be taken:* A full house audit by the Wellness Director is being conducted to verify if any other residents have catheters that would require an exemption- Any non-compliance with the admission regulations will be addressed immediately and reported to the Administrator. Action will occur consistent with the regulations. • *What measures will be put into place or what systemic changes will you make to ensure the deficient practice does not recur:* • The new Wellness Director reviewed the regulations and has been educated on the requirements for exemptions for medical conditions including the need for an indwelling catheter. Direct care staff training is being conducted by the Administrator and Wellness Director on the precluded conditions and the	

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			need for coordinated care plans and filing for exemptions. This training should be completed by 7/25/25. • *How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:* • The Administrator or designee will conduct weekly reviews of resident's conditions to verify compliance with the admission policy/regulations. • Results of these reviews will be documented and reviewed during monthly Quality Assurance and Performance Improvement Meetings (QAPI) meetings for at least the next 3 months to verify compliance and assess any need to alter this plan. *Responsible person, designee: Administrator* *Completion Date: 8/01/25*	