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| DESERT SPRINGS SENIOR LIVING | 6650 W FLAMINGO RD, LAS VEGAS, NEVADA ,89103 |

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| RFG 0001-Deficiencies | 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.<br><br>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.<br><br>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.<br><br>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 | RFG 0001-Deficiencies | | |

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| | of Nevada pursuant to NAC 433.384, and other applicable local and state laws.<br><br>Inspector Comments:<br>This Statement of Deficiencies was generated as a result of a complaint investigation survey completed in your facility on 12/05/25, in accordance with Nevada Administrative Code (NAC), Chapter 449, Residential Facility for Groups.<br><br>The census at the time of the survey was 103.<br><br>The sample size was six.<br><br>There was one complaint investigated.<br><br>The facility received a grade of A.<br><br>Unsubstantiated:<br><br>1. Complaint #12399 was unsubstantiated.<br><br>Substantiated:<br><br>2. Complaint #12330 was substantiated. (See TAG Y1700)<br>3. Complaint #12385 was substantiated. (See TAGs Y393 and Y920)<br><br>The investigation into the complaints included:<br><br>Observations including a tour of the facility, residents for falls, resident mobility, call pendant response times and common areas and resident room temperatures.<br><br>Interviews were conducted with residents, including the residents of concern, Caregivers, Medication Technicians, the | | | |

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| | Transportation and Live Enrichment Coordinator, the Environment Services Director and the Administrator.<br><br>Clinical record review of residents, including the residents of concern.<br><br>Document review of facility policies and procedures, Call Pendant Logs, Incident Reports, facility census data and the resident Admission Packet.<br><br>The findings and conclusions of any investigation by the Division of Health Care Purchasing and Compliance 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.<br><br>The following regulatory deficiencies were identified. | | | |
| Y 0393 SS= D | NAC 449.226<br><br>**Safety requirement: Auditory systems for bathrooms and bedrooms –More than 10 residents**<br><br>4. In a residential facility with more than 10 residents:<br><br>(a) Each resident must be provided with, or the bedroom and bathroom of each resident must be equipped with, an auditory system that is monitored by a member of the staff of the facility.<br><br>(b) An auditory system must be available for use in the bathroom of each resident of the facility if the facility was issued its initial license on or after January 14, 1997, so that a resident | Y 0393 | Desert Springs Policy for responding to Call Lights is to respond within 10 minutes.<br><br>A. The Administrator, with the assistance of the Wellness Director, will monitor the Call Light Monitor at the front desk, throughout the day and Review the Previous 24-48 hours of previous call light times, upon return to the community each day.<br><br>B. The Administrator, with the assistance of the Wellness Director and RCC and Front Desk Receptionist will monitor for lengthy call light times.<br><br>C. The Monitoring of call light times for excessive waits began on March 16, 2026.<br><br>D. The Call Light Policy is attached as a document<br><br>E. Desert Springs will continue to assess the care needs of the Assisted Living residents and ensure staffing is adequate to meet the 10 minute goal for all residents. | 03/16/2026 |

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| | needing assistance can alert a member of the staff of the facility of that fact from the toilet and the shower.<br><br>(c) A bathroom that is located in a common area of the facility must be equipped with an auditory system that is monitored by a member of the staff of the facility.<br><br>Inspector Comments:<br><br>Based on observation, document review, record review and interview, the facility failed to answer 1 of 8 resident's call pendants in a timely manner. (Resident #5)<br><br>Findings include:<br><br>Resident #5 (R5)<br><br>R5 was admitted on 05/22/25 with primary diagnoses including history of stroke, depression, osteoporosis and balance problems.<br><br>On 12/02/25 at 8:55 AM, the surveyor pressed the call pendant in R5's room. There was no response from facility staff. Pressed pendant again at 9:55 AM, there was no response from staff. Surveyor pushed button on the wall at 10:05 AM, with no response from staff. The call pendant in the bathroom was not operable.<br><br>R5 explained that one time R5 slid off the couch onto the hardwood floor. R5 kept pushing the call pendant and no one responded. R5 called 911.<br><br>On12/02/25 at 10:02 AM in another resident's room the call pendants in the bedroom and bathroom were pulled, there was no response after 30 minutes.<br><br>The facility's pendant call log for R5 between 11/02/25 and 12/02/25 included the following documentation of staff responses: | | Recent hirings will allow Desert Springs to have a larger caregiving core and will be able better prioritize call light response times. We currently have 4 Caregivers on 1st and 2nd Shift, for 3 days a week and are completing hiring for 7 day a week for 4 caregivers on 1st and 2nd shift. | |

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| | 11/02/25 - 4 events/calls, 2 staff responses were over 30 minutes (39 and 35 minutes respectively)<br><br>11/03/25 – 4 calls, 1 staff response over 30 minutes (39 minutes) 2 staff responses over 20 minutes (22 minutes and 27 minutes respectively)<br><br>11/22/25 – 2 calls, 1 staff response over 30 minutes (37 minutes)<br><br>11/23/25 – 3 calls, 1 staff response over 30 minutes (46 minutes) 2 staff responses over 20 minutes (21 minutes and 27 minutes respectively)<br><br>11/25/25 – 1 call, staff response was over 30 minutes (58 minutes)<br><br>11/28/25 – 1 call, staff response was over 30 minutes (32 minutes)<br><br>12/02/25 – 1 call, staff response was over 30 minutes (80 minutes)<br><br>On 12/02/25 10:13 AM the Administrator explained this was the resident's home and the residents were told to call 911 if needed. The Administrator verbalized the pull/pushed pendants show up on a central posting. The log showed if assistance was needed or if low battery. It also captured date, time, resident and room number.<br><br>On 12/02/25 at 10:50 AM a Caregiver reported call pendant response time expectation was 10 minutes, it depended on the floor and could be a right away response.<br><br>On 12/02/25 at 11:45 AM the Administrator reported the protocol for call pendant response time was less than 10 minutes.<br><br>On 12/02/25 at 12:20 PM a Medication Technician reported the call pendant response time expectation was less than 10 minutes.<br><br>The facility's Resident Call Light policy (dated 09/08/22), documented a fixed Alert call light button is attached to the wall of | | | |

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| | each restroom of each resident and throughout the community in various common area. The goal for responding to each call light is under 10 minutes. Residents may receive assistance after 10 minutes during times where high caregiving is being provide for other residents. If there is a health emergency, the resident can use the alert button in the bathroom.<br><br>Severity: 2 Scope: 1<br><br>Complaint #12385 | | | |
| Y 0920 SS= F | **NAC 449.2748**<br><br>**Medication Storage.**<br><br>1. Medication including, without limitation, any over-the-counter medication stored at a residential facility must be stored in a locked area that is cool and dry. The caregivers employed by the facility shall ensure that any medication or medical or diagnostic equipment that may be misused or appropriated by a resident or any other unauthorized person is protected. Medications for external use only must be kept in a locked area separate from other medications. A resident who is capable of administering medication to himself without supervision may keep his medication in his room if the medication is kept in a locked container for which the facility has been provided a key.<br><br>2. Medication stored in a refrigerator including, without limitation, any over-the-counter medication must be kept in a locked box unless the refrigerator is locked or is located in a locked room.<br>3. Medication including, without | Y 0920 | The Administrator and Wellness Director will continue to monitor any and all residents who self manage their medications and will ensure both the NV Regulations and the Policies for Medication management will be followed. . R5 no longer self-manages her medication based on a change in her condition and approval with the Medicaid Waiver for Assisted Living. | 03/16/2026 |

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| | limitation, any over-the-counter-medication or dietary supplement, must be:<br>(a) Plainly labeled as to its contents, the name of the resident for whom it is prescribed and the name of the prescribing physician; and<br>(b) Kept in its original container until it is administered.<br><br>Inspector Comments:<br><br>Based on observation, document review, record review and interview, the facility failed to ensure a resident who administered their own medications had them secure. (Resident #5)<br><br>Findings include:<br><br>Resident #5 (R5)<br><br>R5 was admitted on 05/22/25 with primary diagnoses including history of stroke, depression, osteoporosis and balance problems.<br><br>The 05/13/25 Physician's Assessment documented the resident was allowed to possess and manage their own medications. The Ultimate User Agreement also indicated R5 administered R5's own medications. | | | |

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| | R5's 07/21/25 Service Plan Report documented: Medication/pharmacy– self administration medications stored and controlled, in locked cabinet, will have re-evaluation for self-medication.<br><br>On 12/02/25 at 8:50 AM, interviewed R5 in the room with a family member present. Medications were unsecured and on the table by R5's wheelchair, on the table where packaged food was sitting, in the bathroom and in a drawer next to R5's wheelchair. This included ones at bedside: Voltaren creme, Meclizine, Melatonin, B12, Diclofenac Sodium, Probiotic fiber, Tylenol, Arthritis pain cream, Clopidogrel 75 mg. It also included medications on the bathroom counter: Hydrocortisone, Triamcinolone Ointment, Nystatin, antibiotic, anti-itch cream, Allergy relief. Much of the medication unsecured in the drawer was expired.<br><br>R5 pointed out the drawer with lock on it for keeping medications.<br><br>R5 explained knowing where the secure place for medications was but said R5 just did not use it. The family member said they knew medications needed to be | | | |

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| | secured.<br><br>On 12/02/25 in the afternoon a Medication Technician acknowledged the unsecured medications in R5's room and bathroom and reported R5 self-administered their medications and had not noticed any problems.<br><br>The facility's Resident Handbook (revised 11/2022), documented under Resident Behavior Code and House Rules, if a resident self-administers medications, refusal to store prescribed and OTC medications in a secured locked location in the resident's apartment is unacceptable.<br><br>The facility's Resident Handbook (revised 11/2022), documented under Where is Medication Kept? section that residents are not to have any medications in their apartment unless an order has been provided to the Wellness Director. Community staff reserve the right to inspect a resident's room in order to ensure compliance with this section. In the event medications are found in a resident's room without the resident having a physician order to self-administer medications, the resident's physician will be informed and the medication will be removed by Wellness staff. | | | |

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| | Severity: 2 Scope: 3<br><br>CPT #12385 | | | |
| Y 1700 SS= D | **NRS 449.1845**<br><br>**Administrator of residential facility for groups to conduct annual assessment of history of each resident and cause provider of health care to conduct certain examinations and assessments; placement based on assessment.**<br>1. The administrator of a residential facility for groups shall:<br>(a) Annually cause a qualified provider of health care to conduct a physical examination of each resident of the facility;<br>(b) Annually conduct an assessment of the history of each resident of the facility, which must include, without limitation, an assessment of the condition and daily activities of the resident during the immediately preceding year; and<br>(c) Cause a qualified provider of health care to conduct an assessment of the condition and needs of a resident of the facility to determine whether the resident meets the criteria prescribed in paragraph (a) of subsection 2:<br>(1) Upon admission of | Y 1700 | The Physician for R3 wrote an updated assessment and assured administration R3 is appropriate for Assisted Living and is not an elopement risk. The administrator and wellness director will continue to monitor and receive updates from her POC regarding the appropriateness of R3. | 03/16/2026 |

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| | the resident to the facility; and<br>(2) If a physical examination, assessment of the history of the resident or the observations of the administrator or staff of the facility, the family of the resident or another person who has a relationship with the resident indicate that:<br>(I) The resident may meet those criteria; or<br>(II) The condition of the resident has significantly changed.<br>2. If, as a result of an assessment conducted pursuant to paragraph (c) of subsection 1, the provider of health care determines that the resident:<br>(a) Suffers from dementia to an extent that the resident may be a danger to himself or herself or others if the resident is not placed in a secure unit or a facility that assigns not less than one staff member for every six residents, any residential facility for groups in which the resident is placed must meet the requirements prescribed by the Board pursuant to subsection 2 of NRS 449.0302 for the licensing and operation of residential facilities for groups which provide care to persons with Alzheimer's disease or other severe dementia.<br>(b) Does not suffer from dementia as described in | | | |

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| | paragraph (a), the resident may be placed in any residential facility for groups.<br>3. As used in this section, “provider of health care” has the meaning ascribed to it in NRS 629.031.<br>(Added to NRS by 2019, 2594)<br><br>Inspector Comments:<br><br>Based on document review, record review and interview, the facility failed to ensure an updated cognitive assessment was completed to retain 1 of 5 residents who displayed a change of condition. (Resident #3)<br><br>Findings include:<br><br>Resident #3 (R3)<br><br>R3 was admitted to the facility on 05/09/25, with diagnoses documented as atrial fibrillation and aphasia.<br><br>R3’s Physician’s Assessment dated 05/09/25, documented R3 was oriented to person, place and time. R3’s physical and mental condition was stable and following a predictable course.<br><br>R3’s Ultimate User Agreement dated 05/09/25, documented R3’s ability to self-administer medications. On 07/15/25, R3’s Ultimate User Agreement documented the facility would manage R3’s medications.<br><br>Physician Progress Notes dated 07/14/25, documented R3’s diagnoses as Alzheimer’s dementia, congestive heart failure and atrial fibrillation.<br><br>The Progress Notes documented R3’s cognition functional status as R3 exhibited | | | |

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| | some difficulty with expressing needs and ideas. R3 understands most conversations, but misses some part/intent of the message. Requires cues at time to understand. Understands only basic conversations or simple, direct phrases.<br><br>One of the medications prescribed to R3 on 07/16/25 was Donepezil, a medication used to treat dementia related to Alzheimer's disease. The physician order documented 1 tablet of 10 milligrams at bedtime.<br><br>On 07/23/25, the facility documented R3's move from independent living to assisted living. R3's needs now included assistance with bathing, dressing, grooming, toileting, reminders to eat and hydration. R3 has at times loss of vocabulary. The document also noted that Wellness staff should be informed as soon any changes of condition were noticed.<br><br>The facility Service Plan Report dated 07/24/25, documented R3 needed reminders to person, place, time, task or personal hygiene.<br><br>A Standard Assessment for Cognitive Abilities dated 09/11/25, documented E3 was not cognitively able to evacuate on their own, and R3 was not cognitively able to go on an outing on their own.<br><br>The Home Health Certification and Plan of Care dated 09/14/25, documented Alzheimer's disease as the principal diagnosis.<br><br>The Plan of Care documented R3 was forgetful. Orders for discipline and treatments included skilled nursing to assess for reduction of activity, restlessness, severe anxiety and suicidal tendencies related to Alzheimer's disease. The Discharge Plan/Goal: R3 would have a behavioral manifestation of absence of disorientation within 6-9 weeks. Sixty | | | |

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| | day summary: Episodes of forgetfulness. R3 has medical history of Alzheimer's dementia.<br><br>On 12/02/25 PM a Caregiver that provided services to R3, explained that R3 sometimes did not comprehend things. The Caregiver reported if there were new visual cognitive issues of concern, they would inform the Director.<br><br>On 12/02/25 at 12:25 PM a Medication Technician reported they had provided services for R3, and at times R3 displayed apparent confusion and did have cognitive issues.<br><br>On 12/02/25 at 1:00 PM, R3 was observed in the common area, watching a movie with friends. A quick cognitive assessment was conducted. R3 explained they had been in the facility for three months, did not know what room they lived in or what day it was. R3 could not remember what they had for lunch. R3 did remember their birthdate and where they were from.<br><br>On 12/02/25 at 1:10 PM, a resident sitting with R3 for the movie reported R3 may forget sometimes.<br><br>On 12/02/25 at 1:35 PM, the Administrator explained that when staff noticed there were changes with R3, the move from independent living to assisted living in the Spring, was initiated and completed.<br><br>The facility's Resident Agreement (revised June 2022), documented the facility may assess resident's health to create and update a personal service plan and/or to determine whether the resident is appropriate to remain at the facility. Based upon the assessment(s) and facility's judgment, the facility may determine the resident's appropriateness to remain in the facility. | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 410 | A. BUILDING _____ B. WING _____ | 12/02/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DESERT SPRINGS SENIOR LIVING | 6650 W FLAMINGO RD, LAS VEGAS, NEVADA ,89103 |

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|---|---|---|---|---|
| | On 12/02/25 in the afternoon, there was no documented evidence of an updated Placement Determination or Physician Assessment after R3's change in condition.<br><br>Severity: 2 Scope: 1<br><br>Complaint #12330 | | | |