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 _____	**04/21/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT VIEW SENIOR LIVING	**3890 N BUFFALO DRIVE, LAS VEGAS, NEVADA ,89129-8809**

(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 Grading, infection control and Complaint Investigation survey conducted at your facility on 04/13/22 through 04/21/22, in accordance with Nevada Administrative Code, Chapter 449, Residential Facilities for Groups. The facility is licensed for 113 Residential Facility for Group beds which provides Assisted Living services for elderly and disabled persons, and/or persons with chronic illness, and/or persons with Alzheimer's disease, 85 Category 1 residents and 28 Category II residents. The census at the time of the survey was 99. Twenty resident records and ten employee records were reviewed. The facility received a grade of B. One complaint was investigated. Complaint #NV00065654 with two allegations was substantiated. (See Tag Y0966.) Allegation #1 - There were only two staff members working in the Memory Care Unit for 18 residents was substantiated. (See Tag Y0966). Allegation #2 - There was only one staff member working both first and second floors in the assisted living side of the facility, with over 50 residents, was substantiated without deficiencies based on review of the regulatory requirements which did not govern staff to resident ratios; and there was no documentation and interview evidence the facility had interrupted the provision of care to residents as a result of staffing issues. The facility was provided guidance on the requirements of NRS 449.101 - Discrimination prohibited; development of nondiscrimination policy; posting of nondiscrimination statement and certain other information, NRS 449.102 - Duties of licensed facility to protect privacy of patient or resident, and LCB File No. R016-20 - Cultural competency training; complaint policy; development of gender identity/expression policy; designated person responsible for compliance with	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: MICHAEL TRAIL Title: Administrator Date: 06/03/2022

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	these regulations. Failure to comply with NRS 449.101, NRS 449.102 and LCB File No. R016-20 may result in future deficiencies. 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:			
0178 SS= D	Health & Sanitation - Maintain Int/ext - NAC 449.209 Health and sanitation. (NRS 449.0302) 5. The administrator of a residential facility shall ensure that the premises are clean and that the interior, exterior and landscaping of the facility are well maintained. Inspector Comments: Based on observation and interview, the Administrator failed to ensure the interior of the facility was well maintained. Findings include: On 04/13/22 in the morning, Caregivers were observed having difficulty opening the locked door leading to the Alzheimer's Care Unit. Caregivers had to enter the access code multiple times to unlock the door. In addition, Caregivers were unable to unlock the doors leading to the courtyard via the internal keypad. The Maintenence Director was able to open both sets of doors with no issues and demonstrate they were fully functional. On 04/13/22 in the afternoon, the Wellness Director and Maintenance Director acknowledged staff members have difficulty opening the door in the Alzheimer's Care Unit which could limit egress from the facility in the case of an emergency and the doors should be able to be opened without the need of special knowledge. Severity: 2 Scope: 1	0178	0178 – Memory Care Doors On 4.19.22 MC Door Vendor, Vortex, arrived, inspected and made adjustments to improve ease in operating the doors for employees and anyone else. Vortex also completed work on 5.17.22 to address key pads and other mechanical parts to ensure greater ease of operation.	05/20/2022
0255 SS= F	Permits-Comply with NAC 446 on Food Service - NAC 449.217 Kitchens; storage of food; adequate supplies of food; permits; inspections. (NRS 449.0302) 6. A	0255	0255 – Kitchen On 4.18.22, Licensed Dietician, Debra	06/03/2022

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	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 04/13/2022, the facility failed to ensure the kitchen and supportive dining services complied with the standards of NAC 446. Findings include: 1. Critical Violations: a. On a shelf in dry storage, there was a dented can of oranges and there were two dented cans of beans in the overflow dry storage in the office. b. Dietary staff were observed to not be washing their hands between duties such as cleaning then prepping food and going from handling dirty ware then handling clean ware without changing gloves and washing hands. 2. Major Violations: a. Multiple food products in dry storage, in the walk-in cooler and in the walk-in freezer were not properly labeled with the product name, preparation or open date and were not covered or sealed. The food products included bulk containers of flour and sugar, macaroni salad, tortillas, frozen fish and frozen rolls. b. The scrap basket in the pre-rinse collector sink in the scullery was cracked, deteriorated and in disrepair. c. There was grime build-up on the interior plastic shield of the ice machine. d. The plastic ice scoop was cracked around the handle. e. Multiple surfaces throughout the kitchen were soiled with food debris, dust and/or grease, including the cook's line ventilation hood, cook's line equipment, lower shelves on tables/equipment, shelving units and the exterior of bulk storage containers. f. The floors were soiled with food and debris under equipment, tables and shelving. g. Coving tiles were broken and in disrepair behind the dish machine. Severity: 2 Scope: 3		Meyer, RDN, LDN, Conducted a Food Service Site Visit to inspect and follow-up on deficiencies found during the Survey 4.13.22. Debra Meyer also conducted an In-service to identify proper handwashing technique and rationale by demonstration. The in-service also covered reasons for hairnets and gloving along with proper use. Copies of the Daily Cleaning Requirements are attached as well. The cooks have a daily cleaning schedule including noted items. A new Kitchen inspection Form will be used daily for the next 30 days and then every other day to ensure items noted do not resurface. The Executive Chef and/or the Administrator or Lead Cook will conduct the inspection. **Critical Violations:** a. Dented cans (3) in dry storage: immediately discarded. Kitchen Inspection Report. b. Dietary Staff observed not practicing proper handwashing between duties: on 4.13.22, Dietician conducted in-service to identify proper handwashing technique with demonstration. **Major Violations:** a. Multiple food products in dry storage not properly labeled: All items were properly labeled. Kitchen Inspection Report. Dietitian conducted in-service on 4.18.22 addressing Proper Food Storage and Labeling. b. Scrap basket in the pre-rinse sink was cracked, and in disrepair: Scrap basket was replaced with a new one and was in place by4.20.2022. Kitchen Inspection Report. c. Grime build-up in the ice machine: Kitchen Inspection Report. Daily Cook Cleaning Item. d. The plastic scoop for ice machine was	

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			cracked: This was replaced with a new scoop by 4.20.2022. Kitchen Inspection Report. e. Multiple surfaces throughout the kitchen were soiled with debris including the ventilation hood: The Dietary Team conducted a thorough deep cleaning of all areas listed. Kitchen Inspection Report. Daily Cook Cleaning Items. f. The floors were soiled with food and debris undersurfaces: The Dietary Team conducted a thorough deep cleaning of all areas listed. Kitchen Inspection Report. Daily Cook Cleaning Items. g. Coving tiles were broken and in disrepair behind the dish machine: New tiles were located. Old tiles were removed and replaced with new tiles. Kitchen Inspection Form.	

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0273 SS= D	Nutrition and Service of Food - Special Diet - NAC 449.2175 4. A resident who has been placed on a special diet by a physician or licensed dietitian must be provided a meal that complies with the diet. The administrator of the facility shall ensure that records of any modifications to the menu to accommodate for special diets prescribed by a physician or licensed dietitian are kept on file for at least 90 days. Inspector Comments: Based on observation, interview, and record review, the facility failed to ensure a special cardiac diet was provided for 1 of 20 sampled residents (Resident #8). Findings include: Resident #8 (R8) R8 was admitted to the facility on 04/04/22 with diagnoses including myocardial infarction, atrial fibrillation, and dementia. The Physical Examination dated 03/21/22 documented R8 was on a cardiac diet. The lunch meal served to R8 on 04/13/22 included beef stew with gravy, potatoes, and a biscuit. The Dietary Manager verbalized the beef stew with gravy, potatoes, and a biscuit was not suitable for a cardiac diet. The Dietary Manager indicated being unaware R8 was supposed to be on a special cardiac diet. The Resident Care Coordinator indicated if a resident was on a special diet, the Caregiver was supposed to communicate the special diet to the Dietary Manager. The Resident Care Coordinator verified the special cardiac diet information for R8 was not communicated to the Dietary Manager. Severity: 2 Scope: 1	0273	0273- Cardiac Diet On 4.18.22 the Administrator presented NAC 449.2175 to the Executive Chef and reviewed. The Administrator informed the Executive Chef to comply with the “Cardiac Diet” for R8. The Administrator, Executive Chef and Resident Care Coordinator reviewed the Procedure for Modified Diets. Additions were made to the Alternative Menu. A copy of the Alternative Menu, with specific items noted for a “Healthy Diet” ,along with a copy of “Nutrition for a Healthy Heart” training, by Debra Meyer,RDN, LDN, were given to R8.	05/20/2022
0393 SS= F	Safety Requirements - NAC 449.226 Safety requirements for residents with restricted mobility or poor eyesight; water hazards; auditory systems for bathrooms and bedrooms; access by vehicles. (NRS 449.0302) 4. In a residential facility with more than 10 residents: (a) Each resident must be provided with, or the bedroom and bathroom of each resident must be equipped with, an auditory system that is	0393	0393- Timely Response to Call Lights The Bath Alert Sensor in the bathroom of R18 was found to be faulty. A replacement sensor was put in place of the faulty one, and programmed through the Philips Call Light System. The Sensor was tested and verified inproper working condition by the Administrator.	05/20/2022

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	monitored by a member of the staff of the facility. (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 needing assistance can alert a member of the staff of the facility of that fact from the toilet and the shower. (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. Inspector Comments: Based on observation, interview, record review and document review, the facility failed to ensure an auditory system was being monitored and residents were assisted with personal care needs in a timely manner. Findings include: Resident #14 (R14) R14 was admitted on 03/12/20, with diagnoses including Multiple Sclerosis and hypertension. R14 reported there were not enough staff to assist with R14's personal care needs. R14 verbalized R14 was left to sit on the toilet for over 10 minutes before a Caregiver came to assist R14. Resident #15 (R15) R15 was admitted on 09/03/21, with diagnoses including hypertension and heart failure. R15 reported R15 had elevated blood pressure and rang R15's call bell for assistance. R15 reported R15 indicating waiting over 30 minutes for a Caregiver to provide R15 assistance. R15 indicated R15 called the front desk for assistance because it took extended periods of time for a Caregiver to arrive. R15 recalled an incident when R15's blood pressure was high. R15 was under physician's orders to notify the Caregiver in order to receive medication for elevated blood pressure. R15 reported there was one Caregiver assigned to the second floor and one Caregiver assigned to the first floor, which was why the Caregivers did not answer call bells in a timely manner. Resident #18 (R18) On 04/13/22 at 11:58 AM, the Health Facilities Inspector observed		Regular monthly tests will be run to ensure proper function of all Bath Sensors throughout the community, with immediate replacement of faulty sensors. The Philips Call Light System is being monitored Daily to determine trends and times of day where heavy care is required. This monitoring also tracks the time taken to answer call lights. This data helps to direct Caregivers to High Priority residents who call more frequently. These records are being kept for review by the administrator and wellness director. Additional Pagers are being purchased to provide extended coverage of call lights.	

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	R18 push the call bell. After 20 minutes and at 12:18 PM, no staff members had shown up to assist R18. The Wellness Director indicated the facility's call bell policy was to assist residents within five to ten minutes. The call response log for a 30-day period (03/15/22 through 04/15/22) documented the following: -A total of 2,472 call bells were pushed. Of these: -119 were not documented as answered. -716 were documented as answered in more than ten minutes. On 04/21/22, the Administrator verbalized an appropriate call bell response time by a staff member was within five to ten minutes, and acknowledged it was unacceptable for staff to fail to respond to resident call bell requests within five to ten minutes. Severity: 2 Scope: 3			
0878 SS= D	Medication/OTCS, Supplements, Change Order - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 5. An over-the-counter medication or a dietary supplement may be given to a resident only if the resident's physician has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician. The administration of over-the-counter medications and dietary supplements must be included in the record required pursuant to paragraph (b) of subsection 1 of NAC 449.2744. 6. Except as otherwise provided in this subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order; (2) Indicate on the container of the medication that a change has occurred; and (Previously Y 0879) (3) Note the change in the record maintained	0878	0878 – Medication/OTC On 5.16.22 a request was sent to the prescribing physician, Dr. Thomas Alfreda, for clarification of the order for Vitamin C for R7. The clarification indicated a serving was 2 capsules = 1500mg, once a day. There is zero documentation on the bottle, the physician’s order or the clarification indicating 1 capsule =1500mg. The serving size on the bottle indicates 2capsules, equaling 1500mg.	05/20/2022

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	pursuant to paragraph (b) of subsection 1 of NAC 449.2744; (b) Within 5 days after the change is ordered, a copy of the order or prescription signed by the physician must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; and (c) If the label prepared by a pharmacist does not match the order or prescription written by a physician, the physician, registered nurse or pharmacist must interpret that order or prescription and, within 5 days after the change is ordered, the interpretation must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744. Inspector Comments: Based on interview and record review, the facility failed to ensure medications were administered per physician's orders for 1 of 20 sampled residents (Resident #7). Findings include: Resident #7 (R7) R7 was admitted on 07/26/19, with diagnoses including hypertension and pre-diabetes. A review of R7's medication administration record (MAR) for the month of March and April, documented Vitamin C capsule, give two capsules by mouth once daily, 2 capsules =1500 milligrams (mg). A physician's order dated 02/18/22, documented Vitamin C capsule, give two capsules by mouth once daily, 2 capsules =1500 mg. R7's medication bottle was labeled Vitamin C capsule, one capsule amount per serving was 1500 mg. On 04/13/22 at 12:30 PM, the Medication Technician acknowledged R7's medication bottle did not match R7's MAR and physician's order. The Medication Technician confirmed R7 was given two capsules to equal 3000 mg daily, and not administered per the physician's order. The Medication Technician indicated R7's physician's order needed to be clarified by the physician. Severity: 2 Scope: 1			

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0966 SS= F	Alzheimer's Care - NAC 449.2754 Residential facility which provides care to persons with Alzheimer ' s disease: Application for endorsement; general requirements. (NRS 449.0302) 5. The administrator of such a facility shall prescribe and maintain on the premises of the facility a written statement which includes: (b) Evidence that the facility has established interaction groups within the facility which consist of not more than six residents for each caregiver during those hours when the residents are awake; Inspector Comments: Based on record review, and interview, the Administrator failed to ensure the facility had established interaction groups of one Caregiver for every six residents during residents' waking hours. Findings include: On 04/13/22 in the morning, a review of the census in the Memory Care unit from 04/08/22 - 04/13/22 revealed a census of 19 residents. On 04/13/22 a review of the Memory Care staffing schedule for April 2022 revealed the following: - On 04/08/22 the schedule showed from 6:00 AM - 8:00 AM there were two caregiving staff for 19 residents. - On 04/09/22 the schedule showed there were two caregiving staff for 19 residents. - On 04/10/22 the schedule showed there were three caregiving staff for 19 residents. - On 04/11/22, 04/12/22 and 04/13/22 the schedule showed from 6:00 AM - 8:00 AM there were three caregiving staff for 19 residents. On 04/13/22 at 9:30 AM, the Wellness Director explained the staffing ratio for the Memory Care side was one caregiver to every six residents. The Wellness Director confirmed the census for the Memory Care unit on 04/13/22 was 20 residents. The Wellness Director acknowledged the Memory Care unit had not met the ratio requirement of one caregiver to every six residents. Severity: 2 Scope: 3 Complaint #NV00065654	0966	0966 – Memory Care Unit Staffing Ratio On the day of the Survey, the census in Memory Care was 19(physical census). The 6:1 ratio requirement was not met as only 3 caregiverswere present and on the schedule in Memory Care. The day after Survey, thephysical census reduced to 18 and has remained. Memory Care Staffing has beenaddressed and trained caregivers are correctly scheduled to meet current andfuture staffing needs in the Memory Care Unit.	05/20/2022