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 _____	**04/02/2024**

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 and complaint investigation survey completed at your facility on 04/02/24, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facilities for Groups. The facility is licensed for 123 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 I residents and 28 Category II residents. The census at the time of the survey was 113. Twenty five resident files and 10 employee files were reviewed. The facility received a grade of A. There was one complaint investigated. Substantiated without Deficient Practice: 1. Complaint #NV00070336 was substantiated with no deficient practice. The investigation of the complaint included: Observation of facility promotional slide show showing facility rooms and amenities. Interviews were conducted with the Business Office Manager, the Operations Manager and the Community Relations Director/Senior Family Advisor. Record review of the resident of concern, including a signed Resident Admission Agreement and discharge documents. Document review including a Resident Admission Agreement and facility complaint log. 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 deficiency was identified.	0000		
0991 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 and R043-22 Residential facility which provides care to persons with	0991	April 15, 2024	04/02/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | Name: MICHAEL EUGENE TRAIL | Title: Administrator | Date: 04/15/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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 _____	**04/02/2024**

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
	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 or other forms of dementia who meet the criteria prescribed in paragraph (a) of subsection 2 of NRS 449.1845 shall ensure that: (b) Operational alarms, buzzers, horns or other technology for notifying staff 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 provide an audible alarm which activated upon opening the door to the Alzheimer's Unit. Findings include: On 04/02/24 at 9:25 AM, the door leading to the Alzheimer's Unit did not have an audible alarm which activated upon opening the door. On 04/02/24 at 9:25 AM, the Maintenance Director acknowledged the alarm did not activate upon opening the door and verbalized the battery needed replacement. On 04/02/24 at 10:30 AM, the Administrator indicated the door to the Alzheimer's Unit should have sounded an alarm upon opening. Severity: 2 Scope: 3		**Plan of Correction** – State of Nevada, DHHS Annual Survey 4.2.2024 1.Alzheimer's Care Standards for Safety – NAC 449.2756 and R043-22, NRS 449.1845 Operational Alarms , buzzers, horns or other technology for notifying staff when a door is opened are installed on all doors that may be used to exit the facility. Findings: Facility failed to provide an audible alarm which activated upon opening the door to the Alzheimer's Unit. The maintenance director acknowledged the alarm did not activate upon opening the door and verbalized the battery needed replacement. ## Action Taken by Desert View: 1.Batteries were replaced in the alarm to the Alzheimer's unit and tested satisfactory on 4.2.2024.	

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 _____	**04/02/2024**

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
			2.Weekly task was added to the Maintenance Director's tasks to inspect and document properly working alarm for Alzheimer's unit door. a. Maintenance Director's weekly maintenance checklist is attached b. Maintenance Director was instructed and trained by Administrator on 4.2.2024, to check the alarm weekly to ensure proper compliance with NAC and NRS. c. Documentation is made on the "TELS" Doors, Locks and Alarms checklist as part of Direct Supply Maintenance System.	