Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8809	A. BUILDING _____ B. WING _____	04/21/2026

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
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. 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. 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. 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8809	A. BUILDING _____ B. WING _____	04/21/2026

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
	of Nevada pursuant to NAC 433.384, and other applicable local and state laws. Inspector Comments: This Statement of Deficiencies was generated as a result of an annual survey completed in your facility on 04/21/26. The facility is licensed for 123 Residential Facility for Group beds for elderly and disabled persons and/or persons with Alzheimer's disease and Mental Illness which provide assisted living services, Category II residents. The census at the time of survey was 118. Twenty-five resident files and nine employee files were reviewed. The facility received a grade of A.			
Y 0172 SS= F	NAC 449.209 2. Containers used to store garbage outside of the facility must be kept reasonably clean and must be covered in such a manner that rodents are unable to get inside the containers. At least once each week, the containers must be emptied, and the contents of the containers must be removed from the premises of the facility. 3. Containers used to store garbage in the kitchen and laundry room of the facility must be covered with a lid unless the containers are kept in an enclosed cupboard that is clean and prevents infestation by rodents or insects. Containers used to store garbage in bedrooms and bathrooms are not required to be covered unless they are used for food, bodily waste or	Y 0172	**Plan of Correction** Facility: **Desert View Senior Living** **Tag Y0172** **Immediate Corrective Action Taken for Residents Affected** **Corrective Action:** 1. The drain receptacle area was immediately cleaned upon identification. **Residents Identified with the Potential to BeAffected:**	04/27/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8809	A. BUILDING _____ B. WING _____	04/21/2026

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
	medical waste. 4. To the extentpracticable, the premises of the facility must be kept free from: (a) Offensive odors; (b) Hazards, including obstacles that impede the freemovement of residents within and outside the facility; (c) Insects and rodents; and (d) Accumulations of dirt, garbage and other refuse. 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 facility failed to repair a leaking pipe connected behind two dryers, fixing the damaged walls underneath, and cleaning the black substances near the pipes. Findings include: On 04/21/2026 in the morning, two pipes connected behind two dryers on the second floor were leaking a bubbly liquid that deteriorated the wall underneath it and formed a black substance near the pipes. On 04/21/2026 in the morning, the Maintenance Director acknowledged the two leaking pipes behind the dryer, the damaged walls, and the black substances, and should have been repaired or cleaned.		A. A full inspection of all residents' laundry rooms was completed to ensure no additional drainage issues or concerns were present. B. All residents utilizing the second-floor laundry facilities were deemed potentially affected due to shared resident use. C. Damaged drywall was repaired to restore the integrity of the area. D. A longer drain hose was purchased and installed to ensure proper drainage and prevent recurrence. **Systemic Changes Implemented to Prevent Recurrence:** 1. The Maintenance Director completed weekly inspections to ensure no further drainage issues were present. 2. Bi-weekly inspections of the laundry rooms will be conducted for one month. 3. Monthly inspections will continue thereafter aspart of routine maintenance monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8809	A. BUILDING _____ B. WING _____	04/21/2026

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
	Severity: 2 Scope: 3			
Y 0393 SS= F	**NAC 449.226** **Safety requirement: Auditory systems for bathrooms and bedrooms –More than 10 residents** 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 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, and document review, the facility failed to ensure the call bell system was set up in 14 of 14 resident bedrooms in Memory Care Unit, to ensure a timely response to residents residing in the Memory Care Unit. Findings include: Resident #12 (R12) R12 was admitted on 10/18/2024, with a	Y 0393	**Tag Y0393** **Safety Requirements: Auditory Systems for Bathrooms and Bedrooms (More Than 10 Residents)** **Corrective Action:** 1. New auditory pull-cord wall units will be installed in unit bathrooms. 2. New auditory wall alert units will be installed on each side of resident rooms. 3. Completion Date: May 6, 2026 4. Ongoing 30-minute rounds are in place until installation is complete. **Residents Identified with the Potential to BeAffected:** A. Full inspection of the bathrooms was completed to check proper functioning of bathroom alert units. B. All residents in the memory care unit were deemed potentially affected by lack of additional alert units in the bedrooms.	04/24/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8809	A. BUILDING _____ B. WING _____	04/21/2026

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
	diagnoses including hypertension, depression, dementia, hyperglycemia, and osteoporosis. On 4/21/2026 in the morning, during a tour of the memory care unit, there was no call button in the resident bedrooms. Additionally, residents in the memory care unit were not wearing call pendants. The resident bathrooms revealed a push button (to activate) an alarm above the toilet paper dispenser. On 04/21/2026 in the morning, R12 verbalized after being admitted to the Memory Care Unit, R12 did not receive a pendant alarm to call for assistance and there was no call button in the bedroom. R12 verbalized not feeling safe without a call button or pendant to contact staff. In R12's bathroom, an alert button was pressed, and no staff members arrived to check on R12 or the call bell pressed for 15 minutes. On 04/21/2026 in the morning, the Maintenance Director and a Medication Technician (Medtech) acknowledged the residents' bedrooms in the Memory Care Unit lacked a call bell button in order to notify staff if residents required assistance. The Maintenance Director and Medtech verbalized the alert button in the residents' bathrooms sent a notification to a pager used by staff members working in the Assisted Living area outside of the Memory Care Unit. The Assisted Living staff were then instructed to call the Memory Care staff to provide the notification a resident had activated an alarm for assistance. On 04/21/26 in the morning, the Maintenance Director indicated the Memory Care staff did not have access to a pager connected to the Memory Care Unit's bedroom and bathroom call buttons in order to be notified if a resident required assistance. The Maintenance Director indicated if Assisted Living staff were notified of the call button in the bathroom being pressed and were in the middle of		**Systemic Changes Implemented to Prevent Recurrence:** 1. An additional pager was issued to Memory Care staff to enhance response and monitoring capability. 2. Resident R12 was issued a wearable pendant on April 24, 2026, to ensure immediate access to assistance **Monitoring:** Maintenance and leadership will verify functionality during routine safety checks.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8809	A. BUILDING _____ B. WING _____	04/21/2026

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
	caring for another resident at the time of the call, it created a delay in the response for the memory care unit resident. On 04/21/26, in the morning, the Maintenance Director and Medtech confirmed the alert button system was monitored by the Assisted Living staff, not the Memory Care Unit staff. The Memory Care Unit resides in the far-right side of the building. To access the memory care unit, staff had to walk down a hallway past approximately 20 rooms to get to the entrance for the Memory Care Unit which led to another hallway of memory care rooms. On 04/21/2026 in the afternoon, the Administrator acknowledged the lack of a call bell system in the memory care residents' bedrooms. The Administrator also acknowledged the memory care unit staff's lack of access to a pager which notified them when a call button was pressed by a resident and that this could create a potential untimely response by staff. On 04/21/26, in the afternoon, the Administrator verified staff completed routine room checks every two hours, however agreed the current call bell process was insufficient due to it creating a delay in provision of care to the residents, and indicated another process should be implemented to ensure safety for residents in the memory care unit. Severity: 2 Scope: 3			
Y 1110 SS= F	**NAC 449.1985 Performance of certain tasks by caregiver.** 5. The training described in this section must be provided by: (a) A physician, physician assistant or licensed nurse; (b) For the training described in paragraph (b) or (c) of subsection 1 of NRS 449.0304, a registered pharmacist; or (c) An employee of the residential facility	Y 1110	**TAG 1110 Performance of Certain Tasks by Caregiver** **Corrective Action:** **In-service training provided by Eldercare Home Health RN (License #RN48322).**	04/24/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8809	A. BUILDING _____ B. WING _____	04/21/2026

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
	who has: (1) Received training pursuant to paragraph (a) of subsection 1 or paragraph (a) of subsection 4, as applicable, from a physician, a physician assistant, a licensed nurse or, if applicable, a registered pharmacist; (2) At least 1 year of experience performing the task for which he or she is providing training; and (3) Demonstrated competency in performing the task for which he or she is providing training. 6. Any training described in this section must include, without limitation: (a) Instruction concerning how to accurately perform the task for which the caregiver is being trained in conformance with nationally recognized infection control guidelines which may include, without limitation, guidelines published by the Centers for Disease Control and Prevention of the United States Department of Health and Human Services; (b) Instruction concerning how to accurately interpret the information obtained from performing the task; and (c) A description of any action, including, without limitation, notifying a physician, that must be taken based on such information. Inspector Comments: Based on interview, record review and document review, the facility failed to ensure staff who took and recorded vital signs and weights were properly trained to do so, for 10 of 10 employees. Findings include: Review of resident files revealed an Ultimate User Agreement present in all 10 sampled resident files, which documented residents agreed to have monthly weights and vitals taken by a community staff member. Facility policy titled Monitoring Weights and Vital Signs, undated, documented it is the practice of the facility to weigh each resident and take their vital signs each month by the 5th of the month.		**Training Details:** 1. Training completed April 24 and April 28, 2026. 2. Final training scheduled for May 6, 2026. **Systemic Changes Implemented to Prevent Recurrence:** A. A full training and evaluation of weights and vital competency was completed, and it was determined care staff required additional training. B. All residents having weighs and vitals performed were deemed as potentially affected due to staff needing additional training on weights, vitals, and parameters. C. Wellness Director or designee will complete a monthly checklist of weights and vitals for the next three months. D. Weights and vital competency training was added to new hire checklist. E. Annual refresher training required for all care staff.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8809	A. BUILDING _____ B. WING _____	04/21/2026

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
	On 04/21/26 in the morning, two caregivers indicated they took and recorded residents blood pressure, pulse oximeter, pulse and weights monthly. The caregivers revealed they had not been formally trained to take residents vitals or weights. Review of facility employee files did not document training to conduct weights or vital signs of residents. On 04/21/26 in the afternoon, the Wellness Director confirmed the facility took and recorded weights and vital signs of all residents, but the staff had not been properly trained to do so. Severity: 2 Scope: 3			