

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295086	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/03/2025
NAME OF PROVIDER OR SUPPLIER Las Ventanas Retirement Comm Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 10401 West Charleston Blvd Las Vegas, NV 89135	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50513</p> <p>Based on observation, interview, record review and document review, the facility failed to ensure a self-administration medication assessment, care plan, physician's orders, and a safe storage area was completed for 1 of 3 sampled residents (Resident 3). The deficient practice had a potential for a resident not to be properly evaluated if able to safely self-administer a nasal spray medication.</p> <p>Findings include:</p> <p>Resident 3 (R3)</p> <p>R3 was admitted on [DATE], with diagnoses including anxiety disorder, chronic obstructive pulmonary disease (COPD), and age-related osteoporosis.</p> <p>On 01/02/2025 at 8:49 AM, a container of saline nasal spray was on R3's overbed tray table. R3 confirmed self-administered the saline nasal spray for when their nose was dry from the oxygen cannula. R3 indicated the saline nasal spray was on overbed tray table to self-administer as needed.</p> <p>On 01/02/2025 at 9:04 AM, the Licensed Practical Nurse (LPN) confirmed resident had a Saline Nasal spray, and there was no physician's order for the Saline Nasal spray or for R3 to self-administer the saline nasal spray.</p> <p>The medical record lacked documented evidence of the following:</p> <ul style="list-style-type: none"> -A self-administration assessment -A care plan for self-administration had been completed -A physician's order had been obtained for R3 to self-administer medication -A physician's order for R3 to receive the saline nasal spray <p>On 01/03/2025 at 9:30 AM, a Registered Nurse (RN) confirmed every resident who wanted to self-administer medication would require a self-administration assessment, a care plan, a physician's order to self-administer, a physician's order for the medication, and must be provided a safe area to store the medication. The self-administration assessment ensured the resident was able to administer the medication correctly and safely.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 01/03/2025 at 10:08 AM, the Director of Nursing (DON) reviewed R3's medical record. The DON confirmed the medical record lacked documented evidence of the following:</p> <ul style="list-style-type: none"> -A self-administration assessment -A care plan for self-administration had been completed -A physician's order had been obtained for R3 to self-administer medication -A physician's order for the R3 to receive the saline nasal spray <p>The Director of Nursing verbalized the resident should not have had the medications in the room or self-administered the Saline Nasal spray.</p> <p>The facility policy titled Resident Self-Administration of Medication revised 02/2021, documented each resident who self-administers medication will have an assessment completed in the medical records, a care plan, and a safe and secure place not accessible by other residents to store the medication. Any medications found at the bedside not authorized for self-administration would be turned over to the nurse in charge and returned to the family or responsible party.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50513</p> <p>Based on observation, interview, record review and document review, the facility failed to ensure a resident was provided supervision during medication administration for 1 of 3 sampled residents (Resident 3). The deficient practice had the potential to place a resident at risk of an accident.</p> <p>Findings include:</p> <p>Resident 3 (R3)</p> <p>R3 was admitted on [DATE], with diagnoses including anxiety disorder, chronic obstructive pulmonary disease (COPD), and age-related osteoporosis.</p> <p>On 01/02/2025 at 8:49 AM, the following was on R3's overbed tray table:</p> <ul style="list-style-type: none"> - a clear plastic medication cup with one white oval tablet - a clear plastic medication cup of 9 various tablets <p>R3 verbalized the nurse had left the oral medications with the resident to take at 9:00 AM.</p> <p>On 01/02/2025 at 9:04 AM, the Licensed Practical Nurse (LPN) verbalized R3 was given their 9:00 AM medications, and the LPN had stepped out of the resident's room to get something from the medication cart before returning to observe the resident take the medication. The LPN revealed should have stayed with R3 until all the medications had been taken.</p> <p>On 01/03/2025 at 9:30 AM, a Registered Nurse (RN) verbalized during medication pass; the nurse must remain at the resident's side to ensure medication was properly taken according to the physician's orders. The RN explained if the resident was not observed taking the medication, the resident could potentially choke or forget to take the medication. The RN revealed a confused resident could potentially wander into the room and take the medication since it was left unsecured in the resident's room.</p> <p>On 01/03/2025 at 10:08 AM, the Director of Nursing verbalized the LPN should have remained by the resident's side until all medication was taken.</p> <p>The facility policy titled Administering Oral Medications revised on 10/2010, documented the facility procedure for medication administration included remaining with the resident until all medications have been taken.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50513</p> <p>Based on observation, interview, record review and document review, the facility failed to ensure medications were secured in; 1) 1 of 2 central supply rooms on the first floor which contained wound care supplies and 2) 1 of 3 sampled resident's room (Resident 3). The deficient practice had the potential risk of unauthorized access to medications, medication errors, theft, or misuse of medication within the facility.</p> <p>Findings include:</p> <p>1. Unsecured Wound care Supplies in a Supply Room</p> <p>On 01/02/2025 at 7:40 AM, the central supply room door was open, the lights were on, and no staff members were in the supply room. The supply room contained wound care supplies.</p> <p>On 01/02/2025 at 8:17 AM, the central supply room door was open, the lights were on and no staff members in the supply room. The following unsecured wound care supplies were located on the shelves in the central supply room:</p> <ul style="list-style-type: none"> -16-ounce bottles of Dakin's solution (a topical antiseptic) -16-ounce bottles of Hydrogen Peroxide (a topical antiseptic) -Petroleum jelly dressings and other medicated wound care dressings -Spray bottle of wound cleanser <p>On 01/02/2025 at 8:18 AM, the Central Supply Clerk entered the room and stated the central supply rooms were never locked so staff can have access to supplies, including wound care supplies. The Central Supply Clerk confirmed the room should have been locked.</p> <p>On 01/02/2025 in the afternoon, the Administrator acknowledged the supply rooms were left opened.</p> <p>On 01/03/2025 at 9:49 AM, the Transport Coordinator stated their desk was located in the Central Supply room with the wound care supplies. The Transport Coordinator advised the door to the room did not have a lock due to staff constantly going in and out of the supply room to obtain needed supplies.</p> <p>The central supply room was supposed to remain open even if the Transport Coordinator or the Central Supply Clerk were not present. The Transport Coordinator verbalized the facility just installed a lock on the door during the night and guidance was given to lock the central supply room door moving forward.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 01/03/2025 at 10:23 AM, the Director of Nursing confirmed the Central Supply room should have been locked because it contained wound care medications.</p> <p>2. Unsecured Medication in a Resident Room</p> <p>Resident 3 (R3)</p> <p>R3 was admitted on [DATE], with diagnoses including anxiety disorder, chronic obstructive pulmonary disease (COPD), and age-related osteoporosis.</p> <p>On 01/02/2025 at 8:49 AM, the following was on R3's overbed tray table:</p> <ul style="list-style-type: none"> - a container of Saline Nasal spray - a clear plastic medication cup with one white oval tablet - a clear plastic medication cup of 9 various tablets <p>The following over the counter medications were on a storage rack in the resident's bathroom and contained the following:</p> <ul style="list-style-type: none"> - a tube of topical analgesic cream - three 15 milliliter containers of lubricant eye drops <p>On 01/02/2025 at 9:04 AM, the Licensed Practical Nurse (LPN) revealed were not aware the resident had the above medications in R3's bathroom storage rack. The LPN acknowledged the saline nasal spray was left unsecured on the resident's bedside tray table.</p> <p>On 01/03/2025 at 9:30 AM, a Registered Nurse (RN) stated medication should never be left out, as it was considered unsecured. The RN stated it was dangerous not only for the resident, but another confused resident could potentially wander into the room and take the medication.</p> <p>The facility policy titled Medication Labeling and Storage revised on 02/2023, documented all medications and biologicals, including antiseptics and disinfectants, must be stored in locked compartments with only authorized personnel having access to keys.</p>		