

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 06/11/2026
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)		
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and document review, the facility failed to document a Nurse Practitioner license number on a Provider Order for Life-Sustaining Treatment (POLST) form for 1 of 29 residents (Resident 65). The deficient practice had the potential to result in uncertainty regarding the validity of the POLST and the resident's end of life treatment preferences. Findings include: Resident 65 (R65) was admitted [DATE], with diagnosis including chronic obstructive pulmonary disease, anxiety disorder, and nausea with vomiting. R65's electronic medical record documented Do Not Resuscitate (DNR) POLST, Medical Interventions Comfort-Focused Treatment, No Hospitalizations. A review of R65's POLST form revealed it was signed by a Nurse Practitioner (NP) on 04/20/2025 and the signature was not legible. The required provider license number field for a Physician/Advanced Practice Registered Nurse (APRN)/Physician's Assistant (PA) license number was left blank. On 06/11/2026 at 7:45 AM, the Director of Staff Development (DSD) confirmed R65's POLST lacked the NP's license number. The DSD explained the Interdisciplinary Team should have reviewed R65's chart, including the POLST on admission to identify discrepancies or missing information. The DSD explained the provider license number was required on the POLST to validate the authorized provider was aware of the order and the resident's end of life choices. The DSD acknowledged the POLST's provider license number field should not have been left blank. On 06/11/2026 at 12:30 PM, the Director of Nursing (DON), confirmed R65's POLST lacked the NP's license number. The DON acknowledged the license number was required to identify and verify the provider authorized to sign the form. The DON acknowledged the POLST form should have included the required provider license number. The POLST form indicated, Bolded items are required. Under Validating Signatures Required, the provider's signature, printed name, and license number were identified as required fields. A facility policy titled Advanced Directives revised September 2022, documented a Physician Orders for Life-Sustaining Treatment (or POLST) paradigm form was a form designed to improve patient care by creating a portable medical order form that records patient treatment wishes so that the emergency personnel know what treatments the patient wants in the event of a medical emergency, taking the patient's current medical condition into consideration.		

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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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record and document review the facility failed to provide foot care or treatments for 1 of 29 residents (Resident 48) who exhibited dry, flaky, and non-viable (dead) skin on both feet. The deficient practice had the potential to cause pain, infection, skin breakdown, and compromised mobility. Findings include: Resident 48 (R48) was admitted on [DATE] with diagnoses including chronic diastolic (congestive) heart failure. On 06/10/2026 at 10:42 AM, R48's right and left feet exhibited poor skin integrity, characterized by dry, flaky, non-viable (dead) skin in the interdigital spaces and on the plantar surfaces. On 06/10/2026 at 10:45 AM, R48 indicated nursing assistants did not wash or apply lotion to either foot. R48 reported when requesting these care tasks, staff express there was no time to perform foot hygiene or apply lotion. On 06/10/2026 at 2:30 PM, a Certified Nursing Assistant acknowledged R48's feet were dry and have non-viable (dead) skin present. On 06/10/2026 at 2:34 PM, a Licensed Practical Nurse, confirmed that R48's right and left feet required foot care and acknowledged the resident's feet exhibited extremely dry skin. On 06/10/2026 at 2:48 PM, the Director of Nursing confirmed R48's feet were dry and had not been cared for. Director of Nursing acknowledged foot care should have been completed as part of R48s routine care. On 06/10/2026 at 2:59 PM, R48s care plan lacked documentation of routine foot care interventions, and there was no evidence of referral to qualified professionals despite visible skin abnormalities. On 06/10/2026 at 3:00 PM, record review revealed R48's medical record did not contain any documented physician orders for foot care. On 06/10/2026 at 3:10 PM, record review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed that R48 required substantial and maximal assistance with personal hygiene. The facility's policy titled Activities of Daily Living (ADLs), Supporting, revised March 2018, documented appropriate care and services would be provided to residents who were unable to perform ADLs independently.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and document review, the facility failed to ensure physician orders were followed for an indwelling urinary catheter and documentation requirements were met in accordance with facility policy for 1 of 29 sampled residents (Resident 33). The deficient practice placed residents at risk for catheter-related complications. Findings include: Resident 33 (R33) was admitted on [DATE], with diagnoses including obstructive and reflux uropathy and benign prostatic hyperplasia. On 06/10/2026 in the morning, R33 laid in bed conversing with a family member. A covered urinary bag was observed hanging on the left side of the bed. A clinical admission assessment dated [DATE], revealed R33 was admitted with an indwelling catheter for urinary retention size 26 French (Fr -diameter size). A physician order dated 04/30/2026, documented urinary catheter 30 Fr/20 cubic centimeters (cc) balloon (amount of sterile waiter used for inflation), as needed for occlusion or leakage as needed. An admission note dated 04/30/2026 revealed R33 was admitted with a three-way Foley catheter size 30 Fr/20 cc balloon which was intact and draining clear yellow urine. On 06/11/2026 at 11:38 AM, the Registered Nurse (RN) assigned to R33 entered the resident's room, viewed R33's Foley catheter and confirmed R33 had a 16 Fr/10 cc Foley catheter. The RN could not speak to why the observation did not align with physician order for a 30 Fr/20cc and deferred to the Licensed Practical Nurse (LPN) who inserted R33's 16 Fr/10 cc Foley catheter. On 06/11/2026 at 11:50 AM, the LPN reported R33 underwent a 72-hour bladder training beginning on 05/01/2026 but failed voiding trials. The LPN indicated the nurse practitioner (NP) ordered a bladder scan which confirmed urinary retention and ordered straight catheterization. According to the LPN, the NP ordered the LPN to insert an indwelling catheter if retention persisted. The LPN acknowledged inserting a 16 Fr/10cc Foley without obtaining clarification from the NP on what size and balloon amount to use and did not check medical record for any active orders for R33's Foley catheter. 06/11/2026 12:14 PM the LPN acknowledged not following physician's order to use a 30 Fr when the LPN inserted a 16 Fr/10cc catheter on 05/05/2026 and failed to follow documentation requirements with regards to catheter insertion. On 06/11/2026 at 12:26 PM, the admission nurse recounted R33 was admitted with a 30 Fr/20 cc Foley catheter and clarified the nursing admission assessment which documented a 26 Fr catheter was a typographical error. The admission nurse indicated the physician's order for a 30cc/20cc was still an active order and it must be discontinued if a provider ordered a new size and balloon amount. On 06/11/2026 at 12:50 PM, the Director of Nursing (DON) indicated expecting nurses to follow physician orders and obtain clarification from the provider if needed. The DON indicated documentation requirements must be met by every nurse inserting a Foley catheter. The facility's Indwelling Catheter Insertion policy revised August 2022, revealed when inserting a Foley catheter the following must be documented in the resident's medical record: date and time procedure was performed, name and title of individual who performed procedure, assessment data such as urine characteristics, size inserted and balloon amount and how resident tolerated the procedure.		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and document review, the facility failed to ensure a peripheral intravenous access (IV) had a dated dressing, and care orders for site assessment and dressing changes were transcribed and carried out for the peripheral IV line and a peripherally inserted central line (PICC) line for 2 of 29 sampled residents (Resident 4 and 45). The deficient practice placed residents at risk for phlebitis (site infection) and sepsis. Findings include: Resident 4 (R4) was admitted on [DATE] with diagnoses including Methicillin Resistant Staphylococcus Aureus (MRSA) and malignant neoplasm of the bladder. On 6/10/2026 at 10:46 AM, R4 laid in bed appearing weak but able to articulate needs. A PICC line was observed on the resident's right upper arm (RUA) with dressing which appeared to read 05/08/26. R4 indicated the dressing was changed at the facility two weeks ago. On 06/10/2026 at 10:51 AM, the Registered Nurse (RN) assigned to R4 observed the PICC line dressing and described it to be not looking new but looking old and interpreted the dressing date as 06/08/26. R4 insisted no one changed the dressing two days ago. When asked about flushing, the RN indicated flushing R4's PICC line this morning. R4 indicated the RN did not flush the PICC line this morning. On 06/10/2026 at 11:03 AM, the Infection Preventionist (IP) indicated the dressing date appeared to read 06/08/26 but described the dressing as not appearing to have been changed two days ago. The IP was in the room when R4 verbalized the PICC line was changed two weeks ago and it had not been flushed this morning. On 06/10/2026 at 12:04 PM, the IP indicated after reviewing R4's medical record it could be confirmed there was no documentation of any nurse-physician discussion regarding removal or maintenance of the PICC line after IV antibiotics were completed on 06/04/2026, and no care orders for site assessment and 3) the dressing change was signed off on 06/07/2026 and flushing on 06/10/26 which did not align with the resident's recollection of care. The IP could not speak to the discrepancy between the resident's recollection of PICC line care versus the RN's claim of having flushed the port and documented dressing change in medical record. Resident 45 (R45) was admitted on [DATE] and readmitted on [DATE], with diagnoses including encounter for surgical aftercare following surgery of the digestive system and malignant neoplasm of small intestine. On 06/10/2026 at 9:51 AM, R45 laid in bed appearing weak. A peripheral IV line was observed in left hand with undated transparent dressing. An empty medication bag hung on an IV pole on the left side of the bed with tubing looping around the pole. R45 indicated receiving IV antibiotics for infection of the duodenum. R45 indicated the IV line was inserted in the hospital. The Clinical admission assessment dated [DATE] lacked documented evidence R45 was admitted with a peripheral IV line on left hand. On 06/10/2026 at 9:55 AM, by direct observation and after reviewing medical record the IP confirmed the admitting nurse failed to identify R45's IV line, there was no documentation of a nurse-physician discussion regarding whether to remove or maintain the peripheral line, and no care orders were transcribed and carried out for site assessment and dressing changes. The IP indicated these missteps placed the resident at risk for phlebitis. On 06/11/2026 at 2:02 PM, the Director of Nursing (DON) indicated the admitting nurse was responsible for identifying and documenting presence of IV accesses. According to the DON the nurse should obtain an order for removal unless ordered to maintain the line. If ordered to maintain the line, care orders for flushing, site assessment and dressing changes would be transcribed into medical records. The DON indicated not following policy placed these residents at risk for infection. The facility's Peripheral and Midline Dressing Changes policy dated June 2025, documented to prevent IV-related complications, perform site care and dressing changes every seven days when using a transparent dressing or when damp, loosened or soiled.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and document review, the facility failed to ensure a restroom soap dispenser contained soap for hand hygiene. The deficient practice had the potential to increase the risk of inadequate hand hygiene and the transmission of infectious organisms. Findings include: On 06/10/2026 at 8:00 AM, reception staff identified two restrooms near the facility's front lobby as the only restrooms designated for staff and visitor use on the facility's first floor. Upon entering the double doors leading to the restrooms, the soap dispenser in the restroom located immediately to the left was observed with a clear soap cartridge completely empty of soap. No alternative soap or hand hygiene products were available in the restroom. On 06/10/2026 at 8:04 AM, a Registered Nurse (RN), confirmed the soap dispenser in the bathroom was empty. The RN explained Housekeeping was in charge of changing the soap cartridges in the restrooms and should have provided a new soap cartridge before it ran out. The RN acknowledged soap should have been available in the restroom for hand hygiene to prevent the spread of infection. 06/10/2026 at 2:31PM, the Infection Preventionist (IP), reported Housekeeping had a routine of checking all soap and sanitizer dispensers including restrooms. The IP acknowledged soap should have been available in the restroom at all times. The IP explained the expectation was staff was to report any empty or broken dispensers to maintenance so that soap dispensers may have been filled. The IP acknowledged the availability of soap in restrooms was part of the facility's standard precautions and important to prevent the spread of infection. A facility policy titled Handwashing/Hand Hygiene revised August 2019 documented all personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. Soap (liquid or bar; anti-microbial or non-antimicrobial) was necessary for hand hygiene. Hand hygiene products and supplies including soap should be readily accessible and convenient for staff to use to encourage compliance with hand hygiene policies.		