

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 11924	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/13/2025
NAME OF PROVIDER OR SUPPLIER VISTA POINTE AT MIRA LOMA		STREET ADDRESS, CITY, STATE, ZIP CODE 2520 WIGWAM PARKWAY, HENDERSON, NEVADA ,89074-6182		
(X4) ID PREFIX TAG RFG 0000- No Deficiencies	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG RFG 0000- No Deficiencies	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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. The RFG was found to be in substantial compliance. No regulatory deficiencies were identified. No further action is necessary. Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation survey completed at your facility on 11/14/25, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 138 Residential Facility for Group beds for elderly and disabled persons with an endorsement for Assisted Living, Mental Illness, and endorsement for Alzheimer's, Category II residents. The census at the time of the survey was 81. Six resident files and six employee files were reviewed. The facility received a grade of A. There was one complaint investigated.			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE Name:

Title:

Date:

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	Unsubstantiated: 1. Complaint #12297 could not be substantiated. No regulatory deficiencies could be identified. The investigation of the complaints included: Observation of breakfast and lunch service, grooming and physical appearance for residents, interactions between staff and residents, staff answering call bells in a timely manner and providing care, and a tour of the facility. Interviews were conducted with residents, Caregivers, Dining Manager, Medical Technicians, the Wellness Director, and the Assistant Administrator. Clinical Record Review of six resident files, which included the residents of concern. Document Review included facility policy and procedures, and dietary menus, and incident reports.			