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 _____	**03/23/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE VISTA	**2000 E PRATER WAY, SPARKS, NEVADA ,89434**

(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 grading re-survey State Licensure survey conducted at your facility on 03/23/22. This survey was conducted by the Division of Public and Behavioral Health in accordance with NAC 449, Residential Facility for Groups. The facility is licensed for 74 Residential Facility for Group beds for elderly and disabled persons and provides assisted living services, Category II residents. The census at the time of survey was 56. Nine resident files were reviewed and five employee files were reviewed. The facility received a grade of A. 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 deficiencies were identified:	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: ROBERT L. MATTS Title: Executive Director Date: 04/12/2022

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 _____	**03/23/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE VISTA	**2000 E PRATER WAY, SPARKS, NEVADA ,89434**

(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
0065 SS= D	Qualifications of Caregivers-Age-Eng-Training - NAC 449.196 Qualifications and training of caregivers. (NRS 449.0302) 1. A caregiver of a residential facility must: (a) Be at least 18 years of age; (b) Be responsible and mature and have the personal qualities which will enable him or her to understand the problems of elderly persons and persons with disabilities; (c) Understand the provisions of NAC 449.156 to 449.27706, inclusive, and sign a statement that he or she has read those provisions; (d) Demonstrate the ability to read, write, speak and understand the English language; (e) Possess the appropriate knowledge, skills and abilities to meet the needs of the residents of the facility; and (f) Receive annually not less than 8 hours of training related to providing for the needs of the residents of a residential facility. Inspector Comments: Based on interview and personnel file review, the facility failed to ensure 1 of 9 sampled employees obtained annual caregiver training (Employee #4). Findings include: Employee # 4 Employee #4 was hired as a Med Tech on 11/12/13. Employee #4's personnel file lacked documented evidence of eight hours of annual caregiver training for 2021. On 11/22/21 at 1:41 PM, the Administrator confirmed Employee #4 was missing the required eight hours of annual caregiver training for 2021. Severity: 2 Scope: 1	0065	This was corrected on initial Survey Accepted POC NRS 449.196Tag 0065(a) Associate raining records to be auditedfor compliance with regulation for initial andannual training. associates found to be outof compliance will be scheduled to completetraining.(b) Training tracking system in place toreview and track training topics, dates andinsure compliance per existing policy.(c) Business Office Manager (BOM) ordesignee will monitor. Training review inprogress. (d)Executive Director (E.D.) will randomlyaudit for compliance for the next twomonths.(e) Completion date: 03/17/2022	04/12/2022

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 _____	03/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE VISTA	**2000 E PRATER WAY, SPARKS, NEVADA ,89434**

(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
0104 SS= D	Personnel Files - Background Checks - NAC 449.200 Personnel files. (NRS 449.0302) 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (f) Evidence of compliance with NRS 449.122 to 449.125, inclusive. Inspector Comments: Based on record review, document review and interview, the facility failed to ensure 1 of 9 employees met the background check requirements of Nevada Revised Statute (NRS) 449.124 (Employee #3). Findings include: Employee #3 Employee #3 was hired at the facility as the Health and Wellness Director 02/07/13. Employee #3's file lacked evidence of fingerprints submitted to the Central Repository for Nevada Records of Criminal History and lacked a Nevada Automated Background Check System (NABS) clearance letter. On 11/22/21 at 1:44 PM, the Administrator confirmed Employee #3 lacked documented evidence of fingerprint submission and lacked evidence of a NABS clearance letter. This was a repeat deficiency from the 09/22/20 annual State Licensure survey. Severity: 2 Scope: 1	0104	This was accepted on Initial Survey Accepted POC NRS 449.200Tag 0104(a) Employee # 3 Background Checkcompleted and Clearance received throughNABS.(b) Review by Business Office Manager(BOM) and Executive Director (E.D.) ofBackground Check regulation and NABssystem completed by January 31, 2022.(c) Business Office Manage (BOM) ordesignee will audit employee records forcompliance with regulation per existingpolicy.(d) Executive Director (E.D.)will randomlyaudit for compliance for next two months.(e) Completion date: 03/17/2022.	03/17/2022
0106 SS= F	Personnel File - 1st Aid & CPR - NAC 449.200 Personnel files 2. The personnel file for a caregiver of a residential facility must include, in addition to the information required pursuant to subsection 1: (a) A certificate stating that the caregiver is currently certified to perform first aid and cardiopulmonary resuscitation; Inspector Comments: Based on record review and interview, the facility failed to ensure caregivers were certified to perform cardiopulmonary resuscitation (CPR) and first aid for 4 of 9 sampled caregivers (Employee #1, #3, #6 and #8). Findings include: Employee #1 Employee #1 was hired as an Executive Director on 10/13/19. The employee's file contained a first aid and	0106	This was Corrected on initial Survey accepted POC NRS 449.200Tag 0106(a) Associate records will be audited forcompliance with regulation for CPR/First Aidtraining. Scheduling training as indicated.(b) Training Tracking/Tickler system put inplace to follow up on raining dates and willschedule training for compliance perexisting policy.(c) Business Office Manager (BOM) ordesignee will monitor Training tickler/reviewlog in place.(d) Executive Director (E.D.) will randomlyaudit for next two months.(e) Completion date: 3/17/2022.	03/17/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**03/23/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE VISTA	**2000 E PRATER WAY, SPARKS, NEVADA ,89434**

(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
	CPR training certificate with an expiration date of January 2020. Employee #1's personnel file lacked documented evidence the employee had a current CPR and First Aid certification. Employee #3 Employee #3 was hired as the Health and Wellness Director 02/07/13. The employee's file contained no first aid and CPR training certificate. Employee #3's personnel file lacked documented evidence the employee had a current CPR and First Aid certification. Employee #6 Employee #6 was hired as a Caregiver on 03/16/21. The employee's file contained no first aid and CPR training certificate. Employee #6's personnel file lacked documented evidence the employee had a current CPR and First Aid certification. Employee #8 Employee #8 was hired as a Caregiver on 04/07/15. The employee's file contained a first aid and CPR training certificate with an expiration date of May 2019; however, the CPR and first aid training were not renewed until 02/06/20. On 11/22/21 at 1:41 PM, the Administrator and Business Office Manager confirmed the lapse in CPR and first aid training and further explained the employees were providing care to the residents during the lapse in the first aid training. The Administrator expressed not having an explanation of why the employee's CPR and first aid training certificate was not current in the personnel files. Severity: 2 Scope: 3			

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 _____	**03/23/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE VISTA	**2000 E PRATER WAY, SPARKS, NEVADA ,89434**

(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
0178 SS= D	Health & Sanitation - Maintain Int/ext - NAC 449.209 Health and sanitation. (NRS 449.0302) 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 remove used paint cans, spray enamel cans, and a cardboard box from the exterior of the facility. Findings include: On 11/22/21 at 9:00 AM, the following were located on the ground outside of a window to a resident's room. - a five gallon paint bucket - two spray enamel cans - six one gallon paint cans - a cardboard box On 11/22/21 at 9:02 AM, the Maintenance Director verbalized the refuse on the ground outside of a resident's window was from a completed painting project. The refuse should have been thrown away and was no longer needed by the facility. Severity: 2 Scope: 1	0178	This was corrected and accepted on initial survey and noted on POC NRS 449.209TAG 0178(a) Inspection of grounds aroundcommunity by Maintenance Director (MT) toinsure trans/debris collected and disposedas appropriate.(b) Routine/weekly grounds inspectionschedule put in place.(c) Maintenance Director (MT) or designeewill perform scheduled inspection ofCommunity grounds.(d) Executive Director (E.D.) will randomlyaudit for next two months.(e) Completion date: 03/17/2022.	03/17/2022

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 _____	**03/23/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE VISTA	**2000 E PRATER WAY, SPARKS, NEVADA ,89434**

(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
0220 SS= D	Laundry & Linen Services Provided - NAC 449.213 Laundry and linen services. (NRS 449.0302) 1. A residential facility shall: (a) Provide laundry and linen services on the premises of the facility; or (b) Contract with a commercial laundry for the provision of those services. 2. A residential facility that provides its own laundry and linen services shall have accommodations which are adequate for the proper and sanitary washing and finishing of linen and other washable goods. 3. The laundry room in a residential facility must be situated in an area which is separate from an area where food is stored, prepared or served. The laundry must be adequate in size for the needs of the facility and maintained in a sanitary manner. The laundry room must contain at least one washer and at least one dryer. All the equipment must be kept in good repair. All dryers must be ventilated to outside the building. If a washer or dryer is located outside the residential facility, the washer or dryer must be in a room or enclosure. Inspector Comments: Based on observation and interview, the facility failed to ensure a resident laundry room did not have lint built up on the back of the dryers, on the floor behind the dryers, and on the electrical cords for the dryers and washing machines for 1 of 1 laundry rooms for resident use. Findings include: On 11/22/21 at 9:17 AM, the resident laundry room had a build up of lint on the back of the dryers, on the floor behind the dryers, on the electrical outlet behind the dryers, and on the electrical cords for the dryers and the washing machines. On 11/22/21 at 9:18 AM, the Maintenance Director verbalized the Maintenance Director did not know when the area behind the washer and dryer had last been swept or dusted and confirmed there was lint behind the dryers. Severity: 2 Scope: 1	0220	This was corrected on initial survey Accepted POC NRS 449.213Tag 0220(a)Maintenance Director (MT) addressedsituation and cleaned area per regulation.(b) Maintenance Director (MT) or designeewill perform routine inspection of area forcompliance.(c) Maintenance Director (MT) or designeewill insure removal of lint per cleaningschedule in accordance with existing policy.(d) Executive Director (E.D.)will randomlyaudit for compliance for next two months.(e) Completion date: 03/17/2022.	03/17/2022

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 _____	**03/23/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE VISTA	**2000 E PRATER WAY, SPARKS, NEVADA ,89434**

(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
0593 SS= D	Rights of Residents; Procedure for Filing - NAC 449.268 Rights of residents; procedure for filing grievance, complaint or report of incident; investigation and response. (NRS 449.0302) 1. The administrator of a residential facility shall ensure that: (d) The facility is a safe and comfortable environment; Inspector Comments: Based on observation, interview, and document review, the facility failed to provide a safe environment for 56 of 56 residents by not ensuring visitors to the facility were screened appropriately for temperature and signs and symptoms of COVID-19 (COVID). Findings include: On 03/23/22 at 8:45 AM, a Resident Assistant (RA) did not screen a visitor to the facility for signs and symptoms of COVID. The RA touched the visitor's forehead with the thermometer and informed the visitor the temperature was 93.1. The RA did not re-take the visitor's temperature and allowed the visitor to proceed through the facility. On 03/23/22 at 8:47 AM, a Medication Technician (MT) verbalized a temperature of 93.1 was not acceptable and the RA should have re-temped the visitor. The MT confirmed the RA should have asked the visitor the screening questions for signs and symptoms of COVID and explained the thermometer should not have touched the visitor when the visitor's temperature was taken. The facility COVID-19 Community Sign In Sheet and Thermometer Use document, undated, documented to keep the thermometer approximately 1/2-11" or so away from forehead and all questions at the top of the log need to be asked and answered for each visit to the community. Severity: 2 Scope: 3	0593	0859 NAC449.274 (a) All Associates present were retrained at time of survey (b) All associates authorized who routinely sign visitors into the community trained (c) Business office manager or designee will audit visitor sign ins to insure compliance with this regulation (d) Executive Director will randomly audit for next two months (e) Completion date: 6/12/2022	04/12/2022

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 _____	03/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE VISTA	**2000 E PRATER WAY, SPARKS, NEVADA ,89434**

(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
0859 SS= D	Medical Care of Resident After Illness - NAC 449.274 Medical care of resident after illness, injury or accident; periodic physical examination of resident; rejection of medical care by resident; written records. (NRS 449.0302) 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by his or her physician. The resident must be cared for pursuant to any instructions provided by the resident ' s physician. Inspector Comments: Based on record review and interview, the facility failed to ensure 2 of 15 sampled residents (Resident #6 and #8) received an annual physical examination. Findings include: Resident #6 Resident #6 was admitted on 10/02/17 with diagnoses including stroke and left side weakness. The resident's file contained an annual physician encounter dated 07/17/18; however, the facility failed to obtain documentation of subsequent physician encounters. On 11/22/21 at 10:30 AM, the Resident Care Coordinator confirmed the resident's record lacked documented evidence of an annual physical exam. Resident #8 Resident #8 was admitted on 03/19/16 with diagnoses including diabetes type II, chronic renal failure, polyneuropathy, and hypertension. The resident's file contained an annual physician encounter dated 10/05/20; however, the file lacked documentation of a current annual physical for Resident #8. On 11/22/21 at 2:15 PM, the Resident Care Coordinator confirmed the resident's record lacked documented evidence of an annual physical exam. Severity: 2 Scope: 1	0859	This was corrected on initial Survey POC NRS449.274Tag 0859(a) Resident records will be reviewed forcompliance with annual physical exams.(b) Health and Wellness Director (HWD) ordesignee will utilize an Annual Physicalexam tickler system to facilitate compliancewith existing policy.(c) Health and Wellness Director (HWD) orResident Care Coordinator (RCC) willmonitor for compliance.(d) Executive Director (E.D.) will randomlyaudit for next two months.(e) Completion date: 03/17/2022.	03/17/2022
0870 SS= D	Medication Administration-Accuracy & Report - NAC 449.2742 Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 1. The administrator of a residential	0870	This was corrected on initial Survey Accepted POC NRS 449.2742Tag 0870(a) Medication review for Resident #14 waslocated in resident record documentattached . All	03/17/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**03/23/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE VISTA	**2000 E PRATER WAY, SPARKS, NEVADA ,89434**

(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
	facility that provides assistance to residents in the administration of medications shall: (a) Ensure that a physician, pharmacist or registered nurse who does not have a financial interest in the facility: (1) Reviews for accuracy and appropriateness, at least once every 6 months the regimen of drugs taken by each resident of the facility, including, without limitation, any over-the-counter medications and dietary supplements taken by a resident; and (2) Provides a written report of that review to the administrator of the facility. (b) Include a copy of each report submitted to the administrator pursuant to paragraph (a) in the file maintained pursuant to NAC 449.2749 for the resident who is the subject of the report. (c) Make and maintain a report of any actions that are taken by the caregivers employed by the facility in response to a report submitted pursuant to paragraph (a). Inspector Comments: Based on record review and interview, the facility failed to ensure a medication profile review was performed by a physician, pharmacist or registered nurse at least once every six months for 1 of 15 residents residing in the facility for longer than six months (Resident #14). Findings include: Resident #14 Resident #14 was admitted on 03/04/21 with diagnoses including chronic obstructive pulmonary disease, hypertension, and abdominal aortic aneurysm. Resident #14's record contained documented evidence of a six-month pharmacy review conducted 10/31/21, which was greater than six months from the date of admission. On 11/22/21 at 1:10 PM, the Health and Wellness Director confirmed the pharmacy review had not been completed within six months of admission to the facility as required. Severity: 2 Scope: 1		resident records will be reviewed for compliance with regulation.(b) 6 month profile review procedures are inplace. Health and Wellness Director (HWD),Resident Care coordinator (RCC) andExecutive Director (E.D.) review per existingregulation.(c) Health and Wellness Director (HWD) ordesignee will review and provide documentsfor signature to Executive Director (E.D.) forsignature upon completed reviews.(d) Executive Director (E.D.) will randomlyaudit for next two months.(e) Completion date 03/17/2022.	

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 _____	03/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE VISTA	**2000 E PRATER WAY, SPARKS, NEVADA ,89434**

(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
0885 SS= D	Medication - Destruction - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 9. If the medication of a resident is discontinued, the expiration date of the medication of a resident has passed, or a resident who has been discharged from the facility does not claim the medication, an employee of a residential facility shall destroy the medication, by an acceptable method of destruction, in the presence of a witness and note the destruction of the medication in the record maintained pursuant to NAC 449.2744. Inspector Comments: Based on observation, record review, and interview, the facility failed to ensure an expired medication was destroyed for 1 of 15 residents (Resident #4). Findings include: Resident #4 Resident #4 was admitted on 10/23/21 with diagnoses to include neuropathy, sleep apnea, hypertension, diabetes, chronic obstructive pulmonary disease, and chronic kidney disease. Resident #4's November 2021 Medication Administration Record (MAR) and physician's order dated 10/25/21 documented calcium carb/cholecalciferol 600 milligrams/800U. Give one tablet orally one time a day. The medication was located with Resident #4's other medications; however, the medication had expired 04/2021. On 11/22/21 at 12:29 PM, the Medication Technician confirmed the calcium was Resident #4's medication. The Medication Technician verbalized the medication was expired and should have been destroyed. Severity: 2 Scope: 1	0885	This was corrected on initial Survey accepted POC NRS 449.2742Tag 0885(a) MAR to cart medications will be audited to insure all medications on hand are no texpired. Expired medication for resident #4was destroyed and replaced with nonexpired medication.(b) Refresher in-service for Med Techs on Medication Rules and identifying out of date medications will be held.(c) Health and Wellness Director (HWD) or designee will audit current medications on hand for expiration date compliance.(d) Executive Director (E. D.) will randomly audit for next two months.(e) 03/17/2022.	03/17/2022
0920 SS= D	Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 1. Medication, including, without limitation, any over-the-counter medication, stored at a residential facility must be stored in a locked area that is cool and dry. The	0920	This was corrected on initial Survey Accepted POC NRS 449.2748Tag 0920(a) Auditing all residents who self medicatefor compliance with regulation. Resident inA111 provided with secure locking storageplaced in apartment within view of residentwhile in	03/17/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**03/23/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE VISTA	**2000 E PRATER WAY, SPARKS, NEVADA ,89434**

(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
	caregivers employed by the facility shall ensure that any medication or medical or diagnostic equipment that may be misused or appropriated by a resident or any other unauthorized person is protected. Medications for external use only must be kept in a locked area separate from other medications. A resident who is capable of administering medication to himself or herself without supervision may keep the resident ' s medication in his or her room if the medication is kept in a locked container for which the facility has been provided a key. 2. Medication stored in a refrigerator, including, without limitation, any over-the-counter medication, must be kept in a locked box unless the refrigerator is locked or is located in a locked room. Inspector Comments: Based on observation, interview, and document review, the facility failed to ensure a medication in a resident room was safely stored in a locked area and inaccessible to other residents or visitors for 1 of 2 rooms of residents who stored insulin in their room (Room A111) and failed to ensure the facility followed the Physician Standard Assessment by allowing a resident to possess medications in their room for self-administration for 1 of 15 residents (Resident #5). Findings include: On 11/22/21 at 10:00 AM, the door to room A111 was open and the resident was asleep in bed and not in view of the doorway or the refrigerator. The refrigerator was unlocked and contained a Lantus Solostar 30 Units per 3 milliliter pen. On 11/22/21 at 10:02 AM, the Licensed Practical Nurse verbalized the insulin pen should be in a secured or locked area or within site of the resident. The facility policy titled "Medications and Treatment - Self-Administration of Medication Policy," last revised 04/2021, documented locking the resident's apartment door was considered the first level for securing medications in an apartment. Resident #5 Resident #5 was		bed etc. Resident #5 moved out of community 12/31/2021.(b) Health and Wellness Director (HWD),Resident Care Coordinator (RCC),Executive Director (E.D.) will reviewregulation and existing policy to insurecompliance with regulation. (c) Health and Wellness Director (HWD) ordesignee with audit all self medicatingresidents upon move in to insureappropriate orders are in place and residentis aware of correct secure storagerequirement and are in compliance withregulation.(d) Executive Director (E.D.) will randomlyaudit for over next two months. (e) Completion date: 03/17/2022.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**03/23/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE VISTA	**2000 E PRATER WAY, SPARKS, NEVADA ,89434**

(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
	admitted to the facility on 10/29/21, with diagnoses to include chronic obstructive pulmonary disease, chronic kidney disease, and osteoporosis Resident #5's clinical record contained an Ultimate User Agreement dated 10/06/21; however, the Ultimate User Agreement did not designate if the resident would possess, monitor, and self-administer medications or if the facility would possess, monitor, and administer medications to the resident. On 11/22/21 at 10:29 AM, the Resident Care Coordinator verbalized the Ultimate User Agreement was not valid for Resident #5. Resident #5's Personal Service Plan dated 10/30/21, documented the resident self-managed their medications including self-administering, ordering, coordinating, and safe storage. Resident #5's Medication Administration Record dated 11/01/21-11/30/21, documented the resident self-administered the following medications: - clobetasol prop - fluticas - magnesium oxide - ofloxacin - spirivia respimat - terazosin - vitamin b-12 - ipratropium -albuteral A Standard Physician's Assessment dated 10/27/21, documented Resident #5 should not be allowed to possess and manage their own medications. On 11/22/21 at 12:20 PM, a Licensed Practical Nurse (LPN) confirmed Resident #5's Ultimate User Agreement was not valid. The LPN admitted the resident possessed and self-administered medications. The LPN confirmed the resident's Standard Physician's Assessment documented the resident was not appropriate to self-manage and administer medications. The LPN confirmed Resident #5's medications were unsecured due to the resident having access to their medications. Facility policy titled "Medication and Treatment - Administration/Assistance," revised 07/2015, documented medication assistance shall be provided in a safe and timely manner, and as prescribed by the resident's health care provider and only persons licensed or permitted by the State			

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 _____	**03/23/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE VISTA	**2000 E PRATER WAY, SPARKS, NEVADA ,89434**

(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
	to prepare, assist, and/or administer and document medications may do so. Severity: 2 Scope: 1			
0923 SS= D	Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 3. Medication, including, without limitation, any over-the-counter medication or dietary supplement, must be: (a) Plainly labeled as to its contents, the name of the resident for whom it is prescribed and the name of the prescribing physician; and (b) Kept in its original container until it is administered. Inspector Comments: Based on observation, interview, and record review the facility failed to label an over the counter (OTC) medication with the resident's name and the ordering provider's name for 1 of 15 residents (Resident #4). Findings include: Resident #4 Resident #4 was admitted on 10/23/21 with diagnoses to include neuropathy, sleep apnea, hypertension, diabetes, chronic obstructive pulmonary disease, and chronic kidney disease. Resident #4's November 2021 Medication Administration Record (MAR) and physician's order dated 10/25/21, documented calcium carb/cholecalciferol 600 milligrams/800U. Give one tablet orally one time a day. The medication lacked documented evidence of the resident's name and ordering provider on the medication. On 11/22/21 at 12:29 PM, the Medication Technician confirmed the calcium was Resident #4's. The Medication Technician verbalized the resident's name and ordering provider's name were not on the medication as required. Severity: 2 Scope: 1	0923	This was corrected on Initial Survey Accepted POC NRS 449.2742Tag 0885(a) MAR to cart medications will be auditedfor correct documentation of Resident nameand prescribing MD name on OTCmedication. (b) Medication Techs will be in-serviced onproper documentation of Resident and MDon OTC medications.(c) Health and Wellness Director (HWD) ordesignee will review medications uponarrival to insure correct label in in place.(d) Executive Director (E.D.) will randomlyaudit for next two months.(e) Completion date: 03/17/2022.	03/17/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**03/23/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE VISTA	**2000 E PRATER WAY, SPARKS, NEVADA ,89434**

(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
0936 SS= D	Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he or she permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including, without limitation: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 15 residents met the requirements concerning tuberculosis (TB) testing (Resident #14). Findings include: Resident #14 Resident #14 was admitted on 03/04/21 with diagnoses including chronic obstructive pulmonary disease, hypertension, and abdominal aortic aneurysm. Resident #14's record contained a two-step TB test administered 02/07/21 with a negative result and administered 02/14/21 with a negative result. The TB form did not contain read dates for either TB test. On 11/22/21 at 1:09 PM, the Health and Wellness Director confirmed the TB form did not contain read dates for the two-step administrations. The Health and Wellness Director verbalized the resident came from a skilled nursing facility and skilled nursing facilities did not document TB test read dates. Severity: 2 Scope: 1	0936	This was corrected on initial Survey Accepted POC NAC 449.2749Tag 0936(a) Resident record with "Read dates"obtained from Skilled Nursing facility andattached here. All resident records will beaudited for inclusion of read dates for all TBTests.(b)Health and Wellness Director (HWD) ordesignee will review all resident preadmission TB results for Negative TB resultplacement and read dates or results ofNegative TB Blood test. (c) Health and Wellness Director (HWD ordesignee will review all resident recordsand PPOC upon move in for completed anddocumented dates of TB test placementand read dates.(d) Executive Director will randomly audit fornext two months.(e)Completion date: 3/17/2022	03/17/2022

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 _____	**03/23/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE VISTA	**2000 E PRATER WAY, SPARKS, NEVADA ,89434**

(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
1045 SS= F	Placard - Display - NAC 449.27704 Placard: Issuance and display; failure to comply. (NRS 449.0302) 2. The administrator shall, within 24 hours after receipt of the placard, display or cause the placard to be displayed conspicuously in a public area of the residential facility. Inspector Comments: Based on observation and interview, the facility failed to conspicuously display the letter grade placard from the last annual State Licensure survey. Findings include: On 11/22/21 at 8:30 AM, upon entry to the facility, the letter grade placard from the State Licensure survey dated 09/22/20, was displayed inside of an office and was on a wall behind the office door. On 11/22/21 at 11:48 AM, the Administrator confirmed the letter grade was not posted in an area visible upon entry to the facility and the door to the office where the placard was posted was locked after business hours. Severity: 2 Scope: 3	1045	This was corrected on Initial Survey accepted POC NAC 449.27704Tag 1045(a) Placard was moved during survey afterdiscussion with surveyor regarding 25 year+ location not being brought to communityattention in any prior surveys.(b) Relocated to front entry area to left asentering community.(c) Placard will remain in current locationunless advised/instructed to be moved byState in future.(d) Executive Director (E.D.) will auditlocation for next two months.(e) Completion date 11/22/2021.	03/12/2022