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 _____	**11/29/2022**

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 complaint (CPT) investigation initiated in your facility on 09/09/22 and completed on 10/17/22, in accordance with Nevada Administrative Code (NAC) Chapter 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 the survey was 56. The sample size was five - three current residents and two discharged residents. The facility received a grade A. There was one complaint investigated. Complaint #NV00066839 with the following allegations were investigated: Allegation #1: A resident was given another resident's medications was substantiated (See Y tag 0878). Allegation #2: A resident's refills were not obtained timely and the resident did not have pain medication could not be substantiated due to a lack of evidence. The investigation into the allegation included the following: Interviews were conducted with the Health and Wellness Director and the Executive Director. Record review included Incident Reports, Medication Administration Reports, activities of daily living, and physician communications. Facility policy review included the Medication Error policy and Medication Refills policy. 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 investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following deficiencies were identified:	0000		
0878 SS= D	Medication/OTCS, Supplements, Change Order - NAC 449.2742 - Administration of medication: Responsibilities of	0878	On 12/28/22, Brookdale Vista reviewed	12/29/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | Name: TRACI HOLLINGSWORTH | Title: RFA | Date: 12/29/2022

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.

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	administrator, caregiver and employees of facility. 5. An over-the-counter medication or a dietary supplement may be given to a resident only if the resident's physician has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician. The administration of over-the-counter medications and dietary supplements must be included in the record required pursuant to paragraph (b) of subsection 1 of NAC 449.2744. 6. Except as otherwise provided in this subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order; (2) Indicate on the container of the medication that a change has occurred; and (Previously Y 0879) (3) Note the change in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; (b) Within 5 days after the change is ordered, a copy of the order or prescription signed by the physician must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; and (c) If the label prepared by a pharmacist does not match the order or prescription written by a physician, the physician, registered nurse or pharmacist must interpret that order or prescription and, within 5 days after the change is ordered, the interpretation must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744. Inspector Comments: Based on interview and record review, the facility failed to administer a medication per a physician's order for 1 of 5 sampled residents (Resident #4). Findings include: Resident #4 Resident		policies and retrained care staff and Med Techs on: • 6 rights of medications • ordering policy, tracker implemented 12.29.22 • Medication Administration Policy • Medication error policy • Missed medications, refusals, doctor notice, progress notes and alerting the nurse • Incident Reporting • See attached documents.	

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	#4 was admitted to the facility on 03/03/22 with diagnoses including hyperosmolality, hypernatremia, polyneuropathy, and acute kidney failure. Resident #4's record contained an incident report dated 07/12/22 at 8:00 PM, documenting a medication error had occurred. The incident report documented the resident was given another resident's medication. The incident report did not indicate the other resident, the medication, the investigation, or any adverse side effects to be monitored. Resident #4's record contained documentation of communication sent to and received from the resident's provider. The documentation lacked evidence of the medication administered. On 11/29/22 at 1:01 PM, the Executive Director (ED) confirmed the resident had been given the wrong medications. The ED verbalized the incident occurred prior to taking the ED position. The ED verbalized not knowing what corrective action steps were taken. On 11/29/22 at 1:40 PM, the ED verbalized alert charting should have been documented. Severity: 2 Scope: 1			