STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	443	A. BUILDING _____ B. WING _____	03/07/2023

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

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted at your facility on 03/07/23. 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 or disabled persons and provides assisted living services, Category II residents. The census at the time of survey was 51. Fifteen resident files were reviewed and ten employee files were reviewed. The facility received a grade of D. NAC 449.27706 Resurvey: Application and fee; failure to comply. 2. If the Bureau issues a placard to a residential facility that includes a grade of "C" or "D," the administrator must submit an application to the Bureau for a resurvey of the facility not later than 30 days after the facility receives the placard. The fee for an application for a resurvey is $600 and must accompany the application. 3. The Bureau may revoke the license of a residential facility that is required to submit an application for a resurvey pursuant to subsection 2 if the facility fails to submit the application in accordance with the provisions of that subsection. 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		

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0053 SS= C	Administrator's Responsibilities-Complete Rec - NAC 449.194 Responsibilities of administrator. (NRS 449.0302) The administrator of a residential facility shall: 4. Ensure that the records of the facility are complete and accurate. Inspector Comments: Based on interview and record review, the Administrator failed to ensure the facility maintained complete and accurate personnel records upon hire and annually and resident records upon admission and annually. Findings include: See the following Y Tags: 0074, 0100, 0102, 0104, 0450, 0620, 0936, 1001, and 1540. On 03/07/23 at 11:06 AM, the Executive Director verbalized two reviews of resident records occurred to ensure records were complete. The reviews were conducted by the Critical Care Coordinator or Licensed Vocational Nurse (LVN) and the Health and Wellness Director (HWD). On 03/07/23 at 11:27 AM, the Executive Director explained a sales person initiated resident paperwork upon admission and then the HWD was responsible for the completion of the documentation. A day before the resident's move-in date, the HWD or Executive Director would review the resident's record for complete documentation. On 03/07/23 at 3:51 PM, the Administrator provided the Attestation of Compliance form, signed and dated 03/07/23, confirming the Business Office Manager had conducted a thorough review of the personnel records to determine compliance and any noncompliance found. The Executive Director verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. Severity: 1 Scope: 3	0053	Executive Director has been reeducated on responsibilities of record compliance under the State's regulation. Executive Director will conduct Quartey audits on both personnel and resident records to ensure compliance of State regulations and company policies.	04/19/2023
0074 SS= E	Elder Abuse Training - NRS 449.093 Training to recognize and prevent abuse of older persons: Persons required to receive; frequency; topics; costs; actions for failure to complete. 1. An applicant for a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse	0074	Associates have completed Elder Abuse training effective 4/19/2023, Business Office Manager reeducated on 4/19/2023 regarding state regulation and compliance. Business Office Manager or designee will verify Elder Abuse training is to be completed on first day of new hire, and annually for associates thereafter. Employee #1 unable to attain, employee no longer with the company.	04/19/2023

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	of older persons before a license to operate such a facility, agency or home is issued to the applicant. If an applicant has completed such training within the year preceding the date of the application for a license and the application includes evidence of the training, the applicant shall be deemed to have complied with the requirements of this subsection. 2. A licensee who holds a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must annually receive training to recognize and prevent the abuse of older persons before the license to operate such a facility, agency or home may be renewed. 3. If an applicant or licensee who is required by this section to obtain training is not a natural person, the person in charge of the facility, agency or home must receive the training required by this section. 4. An administrator or other person in charge of a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before the facility, agency or home provides care to a person and annually thereafter. 5. An employee who will provide care to a person in a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before the employee provides care to a person in the facility, agency or home and annually thereafter. 6. The topics of instruction that must be included in the training required by this section must include, without limitation: (a) Recognizing the abuse of older persons, including sexual abuse and violations of NRS 200.5091 to 200.50995, inclusive; (b) Responding to reports of the alleged abuse of older persons, including sexual abuse and			

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	violations of NRS 200.5091 to 200.50995, inclusive; and (c) Instruction concerning the federal, state and local laws, and any changes to those laws, relating to: (1) The abuse of older persons; and (2) Facilities for intermediate care, facilities for skilled nursing, agencies to provide personal care services in the home, facilities for the care of adults during the day, residential facilities for groups or homes for individual residential care, as applicable for the person receiving the training. 7. The facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care is responsible for the costs related to the training required by this section. 8. The administrator of a facility for intermediate care, facility for skilled nursing or residential facility for groups who is licensed pursuant to chapter 654 of NRS shall ensure that each employee of the facility who provides care to residents has obtained the training required by this section. If an administrator or employee of a facility or home does not obtain the training required by this section, the Division shall notify the Board of Examiners for Long-Term Care Administrators that the administrator is in violation of this section. 9. The holder of a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care shall ensure that each person who is required to comply with the requirements for training pursuant to this section complies with such requirements. The Division may, for any violation of this section, take disciplinary action against a facility, agency or home pursuant to NRS 449.160 and 449.163. Inspector Comments: Based on personnel file review and interview, the facility failed to ensure 4 of 10 sampled employees received initial elder abuse training prior to beginning work at the facility and annually, thereafter (Employee #1, #3, #9, and #10). Findings include: On 03/07/23, the Business			

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	Office Manager was provided the Personnel Check List to complete for 10 sampled employees. On 03/07/23, the Business Office Manager provided the completed form with the following information: Employee #1 Employee #1 was hired by the facility as Administrator with a start date of 12/12/22. Employee #1 lacked a personnel file with documented evidence of initial elder abuse training. Employee #3 Employee #3 was hired by the facility as Caregiver with a start date of 01/31/23. Employee #3's personnel file contained initial elder abuse training dated 02/02/23, two days late. Employee #9 Employee #9 was hired by the facility as Caregiver with a start date of 10/25/17. Employee #9's personnel file contained elder abuse trainings dated 05/20/21 and 02/21/23; however, the personnel file lacked documented evidence of elder abuse training completed in 2022. Employee #10 Employee #10 was hired by the facility as Medication Technician with a start date of 11/15/22. Employee #10's personnel file contained initial elder abuse training dated 11/18/22, three days late. On 03/07/23 at 3:51 PM, the Administrator provided the Attestation of Compliance form, signed and dated 03/07/23, confirming the Business Office Manager had conducted a thorough review of the personnel records to determine compliance and any noncompliance found. The Executive Director verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. Severity: 2 Scope: 2			

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0100 SS= D	Personnel File - 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: (a) The name, address, telephone number and social security number of the employee; (b) The date on which the employee began his or her employment at the residential facility; (c) Records relating to the training received by the employee; (e) Evidence that the references supplied by the employee were checked by the residential facility. Inspector Comments: Based on observation, interview, and document review, the facility failed to ensure 1 of 10 sampled employees had a personnel file (Employee #1). Findings include: On 03/07/23, the Business Office Manager was provided the Personnel Check List to complete for 10 sampled employees. On 03/07/23, the Business Office Manager provided the completed form with the following information: Employee #1 Employee #1 was hired by the facility as Administrator with a start date of 12/12/22. On 03/07/23, the facility lacked a personnel file for the Administrator. On 03/07/23 at 3:51 PM, the Administrator provided the Attestation of Compliance form, signed and dated 03/07/23, confirming the Business Office Manager had conducted a thorough review of the personnel records to determine compliance and any noncompliance found. The Executive Director verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. Severity: 2 Scope: 1	0100	To monitor for future compliance Business Office Manager or designee will monitor associate files to be in compliance and on site at the community. Business Office Manager has been educated on proper hire policies as of 4/19/2023. Employee #1 no longer with the company, unable to attain. New administrator undergoing hiring process.	04/19/2023

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0102 SS= E	Personnel File - TB Screening - NAC 449.200 Personnel files. 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: (d) The health certificates required pursuant to chapter 441A of NAC for the employee; Inspector Comments: Based on record review, document review, and interview, the facility failed to ensure employees met the requirements concerning tuberculosis (TB) testing and pre-employment physical for 4 of 10 sampled employees (Employee #1, #3, #7, and #9). Findings include: On 03/07/23, the Business Office Manager was provided the Personnel Check List to complete for 10 sampled employees. On 03/07/23, the Business Office Manager provided the completed form with the following information: Employee #1 Employee #1 was hired by the facility as Administrator with a start date of 12/12/22. Employee #1 lacked a personnel file with documented evidence of pre-employment physical and an initial two-step TB test. Employee #3 Employee #3 was hired by the facility as Caregiver with a start date of 01/31/23. Employee #3's personnel file lacked an initial two-step TB test. Employee #7 Employee #7 was hired by the facility as Caregiver with a start date of 01/31/23. Employee #7's personnel file lacked an initial two-step TB test. Employee #9 Employee #9 was hired by the facility as Caregiver with a start date of 10/25/17. Employee #9's personnel file contained an annual one-step TB test administered 12/01/20 and read 12/03/20; however, the personnel file lacked documented evidence of annual TB tests in 2021 and 2022. On 03/07/23 at 3:51 PM, the Administrator provided the Attestation of Compliance form, signed and dated 03/07/23, confirming the Business Office Manager had conducted a thorough review of the personnel records to determine compliance and any noncompliance found. The Executive Director verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. Severity: 2 Scope: 2	0102	The four employees identified in the survey have completed two step TB testing and physical. The BOM audited the remaining personnel files to verify if a two-step TB test and pre-employment physical is present. The BOM or designee will review associate paperwork before the associate starts to verify two step TB skin test and pre-employment physical are completed. Annually BOM will review and have TB skin test completed skin test completed. The Executive Director will randomly audit three personnel files monthly for the next 3 months for compliance. Employee #1 and #10 unable to attain copies and she is no longer with the company.	04/19/2023

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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 and interview, the facility failed to ensure 1 of 10 employees met background check requirements (Employee #1). Findings include: On 03/07/23, the Business Office Manager was provided the Personnel Check List to complete for 10 sampled employees. On 03/07/23, the Business Office Manager provided the completed form with the following information: Employee #1 Employee #1 was hired by the facility as Administrator with a start date of 12/12/22. Employee #1 lacked a personnel file with documented 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 03/07/23 at 3:51 PM, the Administrator provided the Attestation of Compliance form, signed and dated 03/07/23, confirming the Business Office Manager had conducted a thorough review of the personnel records to determine compliance and any noncompliance found. The Executive Director verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. Severity: 2 Scope: 1	0104	To monitor for future compliance Business Office Manager or designee will monitor associate files to be in compliance and on site at the community. Business Office Manager has been educated on proper hire policies as of 4/19/2023. Employee #1 unable to attain, is no longer with the company. New administrator currently in hiring process and pending NABS clearance.	04/19/2023
0450 SS= E	First Aid & CPR - NAC 449.231 First aid and cardiopulmonary resuscitation. (NRS 449.0302) 1. Within 30 days after an administrator or caregiver of a residential facility is employed at the facility, the administrator or caregiver must be trained in first aid and cardiopulmonary resuscitation. The advanced certificate in first aid and adult cardiopulmonary resuscitation issued by the American Red Cross or an equivalent certification will be accepted as proof of that training. Inspector Comments: Based on personnel file review and interview, the facility failed to	0450	Business Office Manager and ED to audit CPR class for personnel files by 4/30/2023 and schedule any upcoming renewal and/or outdated for current associates. New associates will attend standing monthly CPR class to ensure CPR is completed within the first 30 days of hire. Associates in the survey report have completed CPR on 4/19/2023. Business Office Manager was in-serviced on 4/19/2023 on the state regulation and compliance with associate files and CPR policies. As a part of the ED's random audit, the associates CPR certification will be checked.	04/30/2023

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	ensure the Administrator and caregiver received first aid and cardiopulmonary resuscitation (CPR) training within 30 days of employment for 4 of 10 sampled employees. Findings include: On 03/07/23, the Business Office Manager was provided the Personnel Check List to complete for 10 sampled employees. On 03/07/23, the Business Office Manager provided the completed form with the following information: Employee #1 Employee #1 was hired by the facility as Administrator with a start date of 12/12/22. Employee #1 lacked a personnel file with documented evidence of first aid and CPR training completed within 30 days of employment. Employee #5 Employee #5 was hired by the facility as Resident Care Coordinator with a start date of 09/22/22. Employee #5's personnel file contained first aid and CPR training dated 11/08/22. Employee #6 Employee #6 was hired by the facility as Medication Technician with a start date of 10/28/22. Employee #6's personnel file contained first aid and CPR training dated 02/07/23. Employee #8 Employee #8 was hired by the facility as Medication Technician with a start date of 12/19/22. Employee #8's personnel file contained first aid and CPR training dated 02/07/23. On 03/07/23 at 3:51 PM, the Administrator provided the Attestation of Compliance form, signed and dated 03/07/23, confirming the Business Office Manager had conducted a thorough review of the personnel records to determine compliance and any noncompliance found. The Executive Director verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. Severity: 2 Scope: 2			
0620 SS= F	Written Policy on Admissions - NAC 449.2702 Written policy on admissions; eligibility for residency. (NRS 449.0302) 4. Except as otherwise provided in NAC 449.275 and 449.2754, a residential facility shall not admit or allow to remain in the facility any person who: (a) Is bedfast; (b) Requires restraint; (c) Requires confinement in locked quarters; or (d) Requires skilled nursing or other medical supervision on a 24-hour basis. Inspector Comments: Based on record	0620	HWD will submit all waivers to the State of current residents who receive hospice or home health services by 4/30/2023. As residents' conditions and need change HWD or designee will submit waiver to the State upon doctor referral for hospice and or home health services of a resident. HWD has been in serviced on new regulation and will do monthly resident review of care needs.	04/30/2023

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	review and interview, the facility failed to ensure a resident receiving skilled nursing services was not allowed to admit or remain in the facility for 9 of 9 residents receiving skilled nursing services (Resident #5, #13, #16, #17, #18, #19, #20, #21 and #22). Findings include: Resident #5 Resident #5 was admitted to the facility on 04/13/22 with diagnoses including heart failure, hyperlipidemia, essential hypertension and paroxysmal atrial fibrillation. Resident #13 Resident #13 was admitted to the facility on 11/02/22, with a diagnosis of hemiplegia following a stroke. Resident #16 Resident #16 was admitted to the facility on 12/15/21, with a diagnosis including major depressive disorder and Parkinson's disease. Resident #17 Resident #17 was admitted to the facility on 04/08/21, with diagnosis of vitamin D deficiency, hyperlipidemia, chronic pain, not elsewhere classified and essential (primary) hypertension. Resident #18 Resident #18 was admitted to the facility on 06/10/21, with diagnoses including gastro-esophageal reflux disease without esophagitis, hyperlipidemia, unspecified, hypo-osmolality and hyponatremia, psychotic disorder due to known physiological condition and schizophrenia. Resident #19 Resident #19 was admitted to the facility on 01/22/22, with diagnoses including unspecified glaucoma, hypothyroidism, unspecified, hyperlipidemia, unspecified, mild cognitive impairment of uncertain or unknown etiology, and atherosclerotic heart disease of native coronary artery without angina pectoris. Resident #20 Resident #20 was admitted to the facility on 10/22/22, with diagnoses including essential (primary) hypertension and heart failure, unspecified. Resident #21 Resident #21 was admitted to the facility on 12/23/21, with diagnoses including thrombocytopenia, unspecified, hypothyroidism, unspecified, hyperlipidemia, unspecified and unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Resident #22 Resident #22 was admitted to the facility on 11/02/22, with diagnoses including hypothyroidism, unspecified, hyperlipidemia, unspecified,			

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	hypo-osmolality and hyponatremia, heart failure, unspecified and hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. On 03/07/23 at 9:47 AM, the Health and Wellness Director (HWD) confirmed the facility had residents receiving skilled nursing care through hospice agencies. The HWD explained the HWD was not aware of the requirement to submit waivers to the State Agency for residents receiving skilled nursing care. The HWD confirmed the facility had not submitted waivers to the State Agency to admit or retain residents receiving skilled nursing care. Severity: 2 Scope: 3			
0644 SS= C	Posting Requirements - 1. A person who operates a residential facility for groups shall: (a)?Post his or her license to operate the residential facility for groups; (b)?Post the rates for services provided by the residential facility for groups; and (c)?Post contact information for the administrator and the designated representative of the owner or operator of the facility, in a conspicuous place in the residential facility for groups. Inspector Comments: Based on observation and interview, the facility failed to ensure the Administrator's license, the Administrator's designee, and the facility's service rates were posted in a conspicuous place as required by NRS 449.184(1). Findings include: On 03/07/23 at 10:06 AM, the Administrator was not in the facility and the Administrator's designee information was not posted in a conspicuous place. The Administrator's license and the facility's rates were posted in the Business Office Coordinator's office behind the inward swinging door. On 03/07/23 at 10:06 AM, the Executive Director confirmed the designee information was not posted in a conspicuous place. The Executive Director verbalized the Administrator's license and the facility's rates had been posted behind the office door for at least 25 years and was unaware the information was required to be posted in a conspicuous place available to be viewed by the public. Severity: 1 Scope: 3	0644	As of 4/19/2023 Rates and administrator license are posted in front lobby entrance where visitors check in.	04/19/2023

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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 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 document review, 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 sampled residents residing in the facility for longer than six months (Resident #7). Findings include: Resident #7 Resident #7 was admitted to the facility on 03/30/22, with diagnoses including major depressive disorder, recurrent unspecified, unspecified urinary incontinence and gastroesophageal reflux disease without esophogitis. Resident #7's clinical record included a medication review completed on 10/31/22, seven months after the date of admission. On 03/07/23 at 11:30 AM, the Executive Director confirmed the medicaiton review dated 10/31/22 was a month late and verbalized all medication reviews were to be completed every six months. Severity: 2 Scope: 1	0870	Documentation of medication review is now on site as of 4/19/2023. The HWD or designee will review resident files to confirm medication profile review is present. The HWD has been re-educated on medication profile review policy. For the next three months, the ED will review five resident files each month to confirm medication profile review has been completed and is on file.	04/19/2023
0878	Medication/OTCS, Supplements, Change	0878	Training for all medication staff is scheduled	05/03/202

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SS= E	Order - NAC 449.2742 - Administration of medication: Responsibilities of 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 clinical record review, document review and interview, the facility failed to ensure medications were on-site and available to administer as prescribed for 6 of 15 sampled residents (Resident #7, #11, #13, #10, #15 and #5). Findings include: Resident #7 Resident #7 was admitted to		with our pharmacy for 5/3/23, review ordering, documentation, and storage of medications. For the next Quarter, HWD or designee to do weekly cart audits and ED to do monthly cart audits to ensure continued compliance.	3

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	the facility on 03/30/22, with a diagnoses including major depressive disorder, recurrent unspecified, unspecified urinary incontinence and gastroesophageal reflux disease without esophagitis. On 03/07/23, during medication review, the following medication was not onsite and available to administer to Resident #7. -bupropion HCl tablet, 100 milligram (mg). Give one tablet by mouth one time a day related to major depressive disorder. Resident #7's physician order dated 05/04/22, documented bupropion HCl tablet, 100 mg. Give one tablet by mouth one time a day related to major depressive disorder. Resident #7's March 2023 Medication Administration Record (MAR) documented bupropion HCl tablet, 100 mg. Give one tablet by mouth one time a day related to major depressive disorder. The medication had not been administered at any time during the month of March 2023. On 03/07/23 at 1:47 PM, the Medication Technician confirmed Resident #7's bupropion HCL, 100 mg was not onsite and available to administer to the resident. The Medication Technician could not confirm the last time the medication was administered to the resident and verbalized the resident's state of mind could get worse if not taking bupropion for major depressive disorder. Resident #11 Resident #11 was admitted to the facility on 06/10/22, with diagnoses including hyperlipidemia, major depressive disorder and unspecified kidney failure. On 03/07/23, during medication review, the following medications were not onsite and available to administer to Resident #11. -donepezil 5 mg tablet. Take one tablet by mouth at bedtime for memory health. -polyethylene glycol 17 gram (gm)/ one dose. Mix 17 gm in 8 ounces of liquid and take by mouth everyday as needed for constipation. Resident #11's physician orders documented the following medications. -A physician order dated 10/28/22, documented donepezil 5 mg tablet. Take one tablet by mouth at bedtime for memory health. -A physician order dated 10/28/22, documented polyethylene glycol 17 gm/ one dose. Mix 17 gm in 8 ounces of liquid and take by mouth everyday as needed for constipation. Resident #11's			

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	March 2023 MAR documented the following: -donepezil 5 mg tablet. Take one tablet by mouth at bedtime for memory health. -polyethylene glycol 17 gram (gm)/ one dose. Mix 17 gm in 8 ounces of liquid and take by mouth everyday as needed for constipation. On 03/07/23 at 2:10 PM, the Medication Technician confirmed Resident #11's donepezil and polyethylene glycol were not onsite and available to administer. The Medication Technician verbalized the polyethylene had never been onsite and available to administer to the resident since the medication was ordered by the physician. The Medication Technician explained the donepezil was last administered on January 21, 2023 and had not been administered since then to the resident. Resident #13 Resident #13 was admitted to the facility on 11/02/22, with a diagnosis of hemiplegia following a stroke. On 03/07/23, during medication review, the following medications were not onsite and available to administer to Resident #13. -aspirin, 81 mg tablet chew. Take two tablets by mouth everyday. -nitroglycerin 0.4 mg sublingual. Take one tablet sublingually every five minutes as needed for chest pain. May repeat two to three times every five minutes. Resident #13's physician orders documented the following: -A physician order dated 11/02/22, documented aspirin, 81 mg tablet chew. Take two tablets by mouth everyday. -A physician order dated 11/02/22, documented nitroglycerin 0.4 mg sublingual. Take one tablet sublingually every five minutes as needed for chest pain. May repeat two to three times every five minutes. Resident #13's March 2023 MAR documented the following. -aspirin, 81 mg tablet chew. Take two tablets by mouth everyday. -nitroglycerin 0.4 mg sublingual. Take one tablet sublingually every five minutes as needed for chest pain. May repeat two to three times every five minutes. On 03/07/23 at 2:06 PM, the Medication Technician confirmed aspirin and nitroglycerin were not onsite and available to administer to Resident #13. The Medication Technician was unable to confirm the last time either medication was administered to the resident. Resident #10 Resident #10 was admitted to the facility on			

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	10/14/22, with diagnoses including anemia, hypothyroidism, hypertension, and syncope. A physician's order dated 11/10/22, documented Guaifenesin DM 100-10 mg/5 ml, take 10 ml by mouth every six hours as needed for cough/congestion. Resident #10's MAR dated January, February, and March 2023, documented the medication had not been administered. On 03/07/23 at 2:10 PM, a Medication Technician confirmed Guaifenesin DM cough syrup was not available on site for Resident #10. On 03/07/23 at 4:35 PM, the HWD confirmed Guaifenesin DM cough syrup had not been administered to the resident and had not been available onsite at any time following receipt of the order for the medication. Resident #15 Resident #15 was admitted to the facility on 12/19/22, with diagnoses including chronic obstructive pulmonary disease, chronic pain, atrial fibrillation, and multiple sclerosis. A physician's order dated 12/20/22, documented duloxetine HCL oral capsule delayed release sprinkle 30 mg, give one capsule by mouth at bedtime for mood. A physician's order dated 12/22/22, documented lactobacillus oral capsule, give one capsule by mouth one time a day for probiotic. A physician's order dated 12/20/22, documented tolterodine tartrate oral tablet 2 mg, give one tablet by mouth one time a day for urinary spasms. Resident #15's MAR dated January 2023, documented lactobacillus was last administered on 01/29/23. Resident #15's MAR dated February 2023, documented duloxetine HCL was last administered on 02/01/23. The MAR documented tolterodine tartrate was last administered on 02/08/23. On 03/07/23 at 2:04 PM, a Medication Technician confirmed duloxetine HCL, lactobacillus, and tolterodine tartrate were not available on site for Resident #15. On 03/07/23 at 4:28 PM, the HWD confirmed the following medications were not available on site since last administered to Resident #15 as follows: -Lactobacillus was last administered on 01/29/23, -Duloxetine HCL was last administered on 02/01/23, and -Tolterodine was last administered on 02/08/23. Resident #5 Resident #5 was admitted to the facility on 04/13/22 with			

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	diagnoses including heart failure, hyperlipidemia, essential hypertension and paroxysmal atrial fibrillation. A physician's order dated 12/13/22, documented Spiriva Respimat aerosol solution 2.5 micrograms, inhale two puffs daily by mouth one time a day for chronic obstructive pulmonary disease. Resident #5's MAR dated March 2023, documented the medication had not been administered since 8:30 AM on 03/05/23. On 03/07/23 at 1:52 PM, a Medication Technician confirmed Spiriva inhaler was not available on site for Resident #5. On 03/07/23 at 1:58 PM, the HWD confirmed Spiriva inhaler had not been administered to the resident and had not been available onsite since 03/05/23. Severity: 2 Scope: 2			

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0920 SS= F	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 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 and interview, the facility failed to ensure medications on a medication cart were secured for potentially affecting all 51 residents. Findings include: On 03/07/23 at 9:08 AM, the medication cart on the B Hallway was unlocked and the Medication Technician was in a resident room and not in sight of the cart. On 03/07/23 at 9:10 AM, the Medication Technician confirmed the medications were unsecured in the medication cart and accessible to all residents. The Medication Technician verbalized all medications needed to be locked at all times. Severity: 2 Scope: 3	0920	Training for all medication staff is scheduled with our pharmacy for 5/3/23, review ordering, documentation, and storage of medications. For the next Quarter, HWD or designee to do weekly cart audits and ED to do monthly cart audits to ensure continued compliance. HWD and or designee to routinely walk and check that carts are locked at all times when not in use.	05/03/2023
0936 SS= F	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	0936	In-service completed on 4/20/2023 with HWD on state requirements for initial and annual TB screening. Chart audit to be completed by 5/1/2023 of the other residents' files to verify current tb compliance. Monthly audit of resident's charts to verify annual tb placement by HWD or designee will be on going.	05/01/2023

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	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 interview and record review, the facility failed to ensure 10 of 15 sampled residents met the requirements for tuberculosis (TB) testing in accordance with Nevada Administrative Code (NAC) 441A (Resident #4, #13, #3, #12, #1, #10, #15, #12, #3, and #5). Findings include: Resident #4 Resident #4 was admitted to the facility on 07/22/22, with diagnoses including anemia, hypothyroidism and alcohol dependence. Resident #4's first-step TB test was given on 06/10/22 and read negative on 06/13/22. The resident's clinical record lacked documented evidence a second-step TB had been completed. In addition, the TB test lacked documented evidence of a timeframe administered and a timeframe read indicating the TB test had been completed within a 72 hour timeframe. Resident #13 Resident #13 was admitted to the facility on 11/02/22, with a diagnosis of hemiplegia following a stroke. Resident #13's first-step TB test was given on 10/13/22 and read negative on 10/16/22. The resident's clinical record lacked documented evidence a second-step TB had been completed. In addition, the TB test lacked documented evidence of a timeframe administered and a timeframe read indicating the TB test had been completed within a 72 hour timeframe. On 03/07/23 at 11:56 AM, the Heath and Wellness Director confirmed Resident #4 and Resident #13 did not have a two-step TB test completed to include the timeframe's indicating a proper TB test. The Health and Wellness Director explained all residents were required to completed a two-step TB test upon admission to include the time administered and the time read. The times were important to ensure the TB test was completed accurately. Resident #10 Resident #10 was admitted to the facility on 10/14/22, with diagnoses including anemia, hypothyroidism, hypertension, and syncope.			

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	Resident #10's clinical record documented an admission first step TB test placed on 09/26/22 and read negative on 09/29/22 and second step TB test given on 10/10/22 and read negative on 10/13/22. Resident #10's TB testing lacked evidence of the times placed and the times read. On 03/07/23 at 1:07 PM, the HWD confirmed the TB records for Resident #10 lacked the time placed and the time read. The standard of practice for reading TB test was between 48 and 72 hours after placement and accurate test results could not be confirmed without times. Resident #15 Resident #15 was admitted to the facility on 12/19/22, with diagnoses including chronic obstructive pulmonary disease, chronic pain, atrial fibrillation, and multiple sclerosis. Resident #15's clinical record lacked documented evidence an admission first step TB test was done. Resident #15's clinical record documented an admission second step TB test was placed on 07/12/22 and read negative on 07/14/22, the time placed, and the time read were not documented. On 03/07/23 at 1:09 PM, the HWD confirmed the TB records for Resident #15 did not include placement of an admission first step TB test. The HWD confirmed the TB test placed on 07/12/22, was documented as a second step TB test and lacked the time placed and the time read. The standard of practice for reading TB test was between 48 and 72 hours after placement and accurate test results could not be confirmed without times. Resident #1 Resident #1 was admitted to the facility on 01/05/23, with diagnoses including atrial fibrillation and diabetes mellitus type I. Resident #1's clinical record documented an admission first step TB test placed on 01/06/23 and read negative on 01/08/23. Resident #1's TB testing lacked evidence of the time placed and the time read. Resident #1's clinical record lacked documented evidence a second step TB test was done. On 03/07/23 at 1:40 PM, the HWD confirmed documentation for Resident #1's TB testing lacked the time placed and the time read. The standard of practice for reading TB test was between 48 and 72 hours after placement and accurate test results could not be confirmed without			

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	times. The HWD confirmed a second step TB test was not completed for Resident #1. Resident #12 Resident #12 was admitted to the facility on 02/22/23 with diagnoses including acute respiratory failure with hypoxia and chronic obstructive pulmonary disease. Resident #12's first step TB test was read negative on 01/25/23 at 7:26 PM. The facility lacked documented evidence of the date/time the TB test was given. Resident #12's second step TB test was read negative on 02/05/23 without a time. The facility lacked documented evidence of the date the TB test was given. On 03/07/23 at 11:02 AM, the Executive Director verbalized the times given and read needed to be documented to confirm appropriate time interval occurred in between given and read. On 03/07/23 at 11:24 AM, the Executive Director confirmed Resident #12's initial TB tests lacked the dates given and a time the second step was read. Resident #3 Resident #3 was admitted to the facility on 10/12/22 with diagnoses including cognitive impairment and diabetes mellitus type II. Resident #3 had a first step TB test given on 10/09/22 at 12:55 PM and read negative on 10/11/22 at 3:51 PM. The facility lacked documented evidence of a second step TB test. On 03/07/23 at 11:02 AM, the Executive Director confirmed the second step was not in Resident #3's record. On 03/07/23 at 12:04 PM, the HWD verbalized the facility was still looking for Resident #3's second step. The facility failed to provide the survey team evidence of the resident's second step upon survey team's exit. Resident #5 Resident #5 was admitted to the facility on 04/13/22 with diagnoses including heart failure, hyperlipidemia, essential hypertension and paroxysmal atrial fibrillation. Resident #5's annual TB test was given on 05/10/22 and read negative on 06/13/22. The TB test lacked documented evidence of a timeframe administered and a timeframe read indicating the TB test had been completed within a 48 to 72 hour timeframe. On 03/07/23 at 11:46 AM, the HWD confirmed Resident #5's annual TB test lacked the time given and read and verbalized the test results could not confirmed without times. The facility policy titled "Tuberculosis			

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	Screening/Testing Policy," revised 01/23, documented residents should be screened or tested for tuberculosis (TB) per state guidelines. Severity: 2 Scope: 3			
1001 SS= D	Elderly Care Training for Caregivers - NAC 449.2758 Residential facility which provides care for elderly persons or persons with disabilities: Training for caregivers. (NRS 449.0302) 1. Within 60 days after being employed by a residential facility for elderly persons or persons with disabilities, a caregiver must receive not less than 4 hours of training related to the care of those residents. Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 8 sampled employees required to receive training to care for elderly and disabled residents received four hours of initial training to care for elderly and disabled residents within 60 days of hire (Employee #8). Findings include: On 03/07/23, the Business Office Manager was provided the Personnel Check List to complete for 10 sampled employees. On 03/07/23, the Business Office Manager provided the completed form with the following information: Employee #8 Employee #8 was hired by the facility as Medication Technician on 12/19/22. Employee #8's personnel file contained documented evidence of three hours of initial caregiver training within 60 days of hire. On 03/07/23 at 3:51 PM, the Administrator provided the Attestation of Compliance form, signed and dated 03/07/23, confirming the Business Office Manager had conducted a thorough review of the personnel records to determine compliance and any noncompliance found. The Executive Director verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. Severity: 2 Scope: 1	1001	Files were reviewed and associates received initial training. BOM or designee will continue to review files to verify four hours of caregiver training is completed or within the first 60 days of employment. For the next Quarter, the ED will review new associate files to confirm compliance.	04/19/2023

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1305 SS= C	Discrimination prohibited - NRS 449.101 Discrimination prohibited; development of antidiscrimination policy; posting of nondiscrimination statement and certain other information; construction of section. [Effective January 1, 2020.] 2. A medical facility, facility for the dependent or facility which is otherwise required by regulations adopted by the Board pursuant to NRS 449.0303 to be licensed shall: (a) Develop and carry out policies to prevent the specific types of prohibited discrimination described in the regulations adopted by the Board pursuant to NRS 449.0302 and meet any other requirements prescribed by regulations of the Board; and (b) Post prominently in the facility and include on any Internet website used to market the facility the following statement: [Name of facility] does not discriminate and does not permit discrimination, including, without limitation, bullying, abuse or harassment, on the basis of actual or perceived race, color, religion, national origin, ancestry, age, gender, physical or mental disability, sexual orientation, gender identity or expression or HIV status, or based on association with another person on account of that person's actual or perceived race, color, religion, national origin, ancestry, age, gender, physical or mental disability, sexual orientation, gender identity or expression or HIV status. Inspector Comments: Based on observation and interview, the facility failed to post a current nondiscrimination statement prominently in the facility. Findings include: On 03/07/23 at 10:08 AM, the facility lacked a current nondiscrimination statement for residents and the public to view. On 03/07/23 at 10:08 AM, the Executive Director acknowledged the facility did not have a nondiscrimination statement posted conspicuously. Severity: 1 Scope: 3	1305	The required documentation and signage has been printed and posted in front lobby area behind front desk. ED or designee will ensure signage remains in a conspicuous place every quarter.	04/19/2023

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	443	A. BUILDING _____ B. WING _____	03/07/2023

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

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1310 SS= C	Discrimination prohibited - NRS 449.101 Discrimination prohibited; development of antidiscrimination policy; posting of nondiscrimination statement and certain other information; construction of section. [Effective January 1, 2020.] 3. In addition to the statement prescribed by subsection 2, a facility for skilled nursing, facility for intermediate care or residential facility for groups shall post prominently in the facility and include on any Internet website used to market the facility: (a) Notice that a patient or resident who has experienced prohibited discrimination may file a complaint with the Division; and (b) The contact information for the Division. 4. The provisions of this section shall not be construed to: (a) Require a medical facility, facility for the dependent or facility which is otherwise required by regulations adopted by the Board pursuant to NRS 449.0303 to be licensed or an employee or independent contractor thereof to take or refrain from taking any action in violation of reasonable medical standards; or (b) Prohibit a medical facility, facility for the dependent or facility which is otherwise required by regulations adopted by the Board pursuant to NRS 449.0303 to be licensed from adopting a policy that is applied uniformly and in a nondiscriminatory manner, including, without limitation, such a policy that bans or restricts sexual relations. (Added to NRS by 2019, 1333, effective January 1, 2020) Inspector Comments: Based on observation and interview, the facility failed to post prominently in the facility the State contact information to file a complaint for a resident who may have experienced prohibited discrimination. Findings include: On 03/07/23 at 10:08 AM, the facility lacked posted documentation of the State contact information to file a complaint for any resident who may experience discrimination. On 03/07/23 at 10:08 AM, the Executive Director acknowledged the State's contact information had not been posted in any common public area of the facility to inform residents where to file a complaint of discrimination. Severity: 1 Scope: 3	1310	The required documentation and signage has been printed and posted in front lobby area behind front desk. ED or designee will ensure signage remains in a conspicuous place every quarter.	04/19/2023

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1540 SS= F	Cultural Competency Training - R016-20 Section 14.1 1. Pursuant to subsection 1 of NRS 449.103, within 30 business days after the course or program is assigned a course number by the Division pursuant to section 18 of this regulation or within 30 business days of any agent or employee being contracted or hired, whichever is later, and at least once each year thereafter, a facility shall conduct training relating specifically to cultural competency for any agent or employee of the facility who provides care to a patient or resident of the facility so that the agent or employee may: (a) More effectively treat patients or care for residents, as applicable; and (b) Better understand patients or residents who have different cultural backgrounds, including, without limitation, patients or residents who fall within one or more of the categories in paragraphs (a) to (f), inclusive, of subsection 1 of NRS 449.103. Inspector Comments: Based on personnel record review and interview, the facility failed to ensure cultural competency training was completed timely for 5 of 9 sampled employees required to obtain cultural competency training (Employees #2, #4, #5, #6, and #10). Findings include: On 03/07/23, the Business Office Manager was provided the Personnel Check List to complete for 10 sampled employees. On 03/07/23, the Business Office Manager provided the completed form with the following information: Employee #2 Employee #2 was hired by the facility as Health and Wellness Director with a start date of 08/01/22. Employee #2's personnel file contained a cultural competency training certificate dated 11/30/22. Employee #4 Employee #4 was hired by the facility on 08/01/14 and started as Executive Director 08/15/22. Employee #4's personnel file contained a cultural competency training certificate dated 10/11/22. Employee #5 Employee #5 was hired by the facility as Resident Care Coordinator with a start date of 09/22/22. Employee #5's personnel file contained a cultural competency training certificate dated 11/17/22. Employee #6 Employee #6 was hired by the facility as Medication Technician with a start date of	1540	The BOM reviewed the personnel files for the community's associates to verify cultural competency training has been completed. The BOM or designee is having new hires complete training on the first date of hire moving forward to ensure 30-day compliance is completed. Monthly personnel file audits will be completed by BOM or designee to ensure annuals are done within the allotted time frame. Inservice with BOM was completed on 4/20/2023 of requirements. Employee #10 is no longer with the company, unable to attain.	04/20/2023

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	10/28/22. Employee #6's personnel file contained a cultural competency training certificate dated 02/23/23. Employee #10 Employee #10 was hired by the facility as Medication Technician with a start date of 11/15/22. Employee #10's personnel file lacked documented evidence of cultural competency training. On 03/07/23 at 3:51 PM, the Administrator provided the Attestation of Compliance form, signed and dated 03/07/23, confirming the Business Office Manager had conducted a thorough review of the personnel records to determine compliance and any noncompliance found. The Executive Director verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. Severity: 2 Scope: 3			
1700 SS= D	Annual Assessment of History of Each Resident - NRS 449.1845 Administrator of residential facility for groups to conduct annual assessment of history of each resident and cause provider of health care to conduct certain examinations and assessments; placement based on assessment. 1. The administrator of a residential facility for groups shall: (a) Annually cause a qualified provider of health care to conduct a physical examination of each resident of the facility; (b) Annually conduct an assessment of the history of each resident of the facility, which must include, without limitation, an assessment of the condition and daily activities of the resident during the immediately preceding year; and (c) Cause a qualified provider of health care to conduct an assessment of the condition and needs of a resident of the facility to determine whether the resident meets the criteria prescribed in paragraph (a) of subsection 2: (1) Upon admission of the resident to the facility; and (2) If a physical examination, assessment of the history of the resident or the observations of the administrator or staff of the facility, the family of the resident or another person who has a relationship with the resident indicate that: (I) The resident may meet those criteria; or (II) The condition of the resident has significantly changed. 2. If, as a result of an assessment conducted pursuant to	1700	HWD was reeducated on 4/20/2023 for chart compliance of resident assessments and physician determinations. A chart audit of residents has started and is to be completed with physician determination forms are up to date with proper placement forms by 5/1/2023. Monthly chart review is done by HWD or designee to ensure continued compliance of regulation. For the next Quarter, the ED will randomly audit three resident files monthly to verify Physican determination forms are present and accurate.	05/01/2023

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	paragraph (c) of subsection 1, the provider of health care determines that the resident: (a) Suffers from dementia to an extent that the resident may be a danger to himself or herself or others if the resident is not placed in a secure unit or a facility that assigns not less than one staff member for every six residents, any residential facility for groups in which the resident is placed must meet the requirements prescribed by the Board pursuant to subsection 2 of NRS 449.0302 for the licensing and operation of residential facilities for groups which provide care to persons with Alzheimer's disease or other severe dementia. (b) Does not suffer from dementia as described in paragraph (a), the resident may be placed in any residential facility for groups. 3. As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031. (Added to NRS by 2019, 2594) Inspector Comments: Based on record review and interview, the facility failed to obtain physician determinations for resident placement prior to admission for 2 of 15 sampled residents (Resident #12 and #3). Findings include: Resident #12 Resident #12 was admitted to the facility on 02/22/23 with diagnoses including acute respiratory failure with hypoxia and chronic obstructive pulmonary disease. Resident #12's physician determination for placement was not dated and placement in a memory care facility for Alzheimer's disease or related dementia had been marked and then crossed out. The cross out was not initialed. On 03/07/23 at 11:22 AM, the Executive Director confirmed the physician determination was not dated and the correction with the crossed out memory care placement should have been initialed. Resident #3 Resident #3 was admitted to the facility on 10/12/22 with diagnoses including cognitive impairment and diabetes mellitus type II. Resident #3's physician determination for placement dated 10/11/22, indicated the resident required placement in a memory care facility for Alzheimer's disease or related dementia. On 03/07/23 at 11:01 AM, the Executive Director confirmed physician determination form indicated the resident was not placed appropriate at the			

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	facility and the resident did have a diagnosis of cognitive impairment. The Executive Director verbalized the facility did not catch the physician's documented placement upon the resident's admission. Severity: 2 Scope: 1			