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 _____	**09/07/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA ADULT CARE	**1079 RICCO DRIVE, 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 investigation completed in your facility on 09/07/21, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The census at the time of the survey was six. The sample size was three. One complaint was investigated. The facility received a grade of A. Complaint #NV00064261 with the following allegations was unsubstantiated. Allegation #1, a resident was wearing three incontinence briefs could not be substantiated due to lack of evidence. Allegation #2, a resident was left on a bedpan resulting in a deep tissue injury could not be substantiated due to lack of evidence. Allegation #3, the facility staff was rough when providing care to a resident could not be substantiated due to lack of evidence. Allegation #4, a resident was not given enough time to eat by facility staff could not be substantiated due to lack of evidence. Allegation #5, a resident was severely dehydrated due to lack of fluid provided by facility staff could not be substantiated due to lack of evidence. The investigation into the allegations included: A tour of the facility including resident rooms. Observations of two incontinent and activities of daily living dependent residents wearing only one brief. Resident care being provided by facility caregivers and residents eating breakfast, snacks, and being offered water. Interviews were conducted with the Owner, the Administrator, two Caregivers, a hospice Registered Nurse for two dependant residents in the facility, and two residents. Review of three resident files included review of physical exams, nursing visit records, plans of care, and progress notes. 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	0000		

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

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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	relief that may be available to any party under applicable federal, state, or local laws. No regulatory deficiencies were identified. No further action necessary. Please retain a copy for your records.			