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 _____ | **10/08/2024** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **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 |
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| 0000 | Initial Comments<br><br>Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation State Licensure survey conducted at your facility on 10/08/2024. This State Licensure Survey was conducted in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility was licensed for seven Residential Facility for Group beds for elderly or disabled persons and/or persons with intellectual disability, two Category I and five Category II residents. The census at the time of the survey was five. Five resident files and three employee files were reviewed. The facility received a grade of B. There were two complaints investigated. Complaint #NV00071799 with an allegation the facility administered medication to a resident belonging to another resident was substantiated (see Tag Y0878). Complaint #NV00072166 with an allegation the facility administered medication to a resident belonging to another resident was substantiated (see Tag Y0878). The investigation revealed the Administrator failed to ensure a the facility had a written staffing schedule, the facility had a Medication Plan, and the facility had a procedure to document and investigate an incident (see Tag Y0088, Y0599, and Y0871). 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 regulatory deficiency were identified: | 0000 | | |
| 0088 SS= C | Staffing Schedule - NAC 449.199 Staffing requirements 4. The administrator of a residential facility shall maintain monthly a written schedule that includes the number and type of members of the staff of the | 0088 | POC TAG 0088<br><br>1) The Facility Administrator | 10/08/2024 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | Name: EVANGELINE MOLINO | Title: RFA | Date: 03/11/2025

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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| | facility assigned for each shift. The schedule must be amended if any changes are made to the schedule. The schedule must be retained for at least 6 months after the schedule expires.<br><br>Inspector Comments: Based on document review and interview, the facility failed to maintain a written staffing schedule, including times when shifts started and ended, the type of staff working, and the day of the month the staff were working. Findings include: On 10/08/2024, upon entry in to the facility, there was no written staffing schedule in the facility with work hours, designation of type of staff working, and identification days of the month the staff were working. On 10/08/2024 at 9:22 AM, the Caregiver confirmed there was no written staffing schedule in the facility. The Caregiver verbalized the Administrator sends the schedule to each employee via a text message. On 10/08/2024 at 12:45 PM, the Administrator confirmed there was no written schedule in the facility and schedules were sent to employees electronically. Severity: 1 Scope: 3 | | will maintain monthly written schedule that includes the number and type of members of the staff of the facility assigned for each shift. The schedule will be amended if any changes are made to the schedule. The schedule will be retained for at least 6 months after the schedule expires.<br><br>2) Effective immediately after the inspector left the facility last 10/08/2024, the Facility Administrator instructed the manager to stop sending to staff the monthly schedule electronically, to be sure that the written schedule includes the number, type of members of the staff of the facility assigned for each shift, the schedule needs to be amended if any changes are made to the schedule, and the schedule will be retained for at least 6 months after the schedule expires.<br><br>3) The Facility Administrator will ensure that the monthly schedule will be printed and displayed in the facility one month ahead. | |

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| | | | 4) Before the end of each month, the Facility Administrator will check the posted monthly schedule regularly.<br><br>5) 10/09/2024<br><br>6) Please see attached printed schedule starting October 2024 to December 2024 | |
| 0599 SS= F | 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) 2. The administrator of a residential facility shall provide a procedure to respond immediately to grievances, incidents and complaints. The procedure must include a method for ensuring that the administrator or a person designated by the administrator is notified of the grievance, incident or complaint. The administrator or a person designated by the administrator shall personally investigate the matter. A resident who files a grievance or complaint or reports an incident pursuant to this subsection must be notified of the action taken in response to the grievance, complaint or report or be given a reason why no action needs to be taken. 3. The employees of the facility shall comply with the procedures adopted pursuant to subsection 2.<br><br>Inspector Comments: Based on clinical record review and interview, the Administrator failed to complete an investigation into an allegation of a medication error by a Caregiver for 1 of 5 sampled residents (Resident #1) and failed | 0599 | POC 0599<br><br>1) The Facility Administrator will provide a procedure to respond immediately to grievances, incidents and complaints. The procedure must include a method for ensuring that the administrator or a person designated by the administrator will be notified of the grievance, incident or complaint. The administrator or a person designated by the administrator will personally investigate the matter. A resident who files a grievance or complaint or reports an incident pursuant to this subsection will be notified of the action taken in response to the grievance, complaint or | 10/15/2024 |

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| | to have a process to document and investigate incidents, affecting 5 of 5 residents in the facility. Findings include: A complaint dated 09/09/2024, documented a reported allegation of a medication error by a Caregiver in July 2024. Resident #1 Resident #1 was admitted to the facility on 04/15/2024 and discharged on 08/22/2024, with diagnoses including non-Hodgkin's lymphoma, chronic encephalopathy, cognitive decline and psychiatric disorder. A physician's order dated 05/21/2024, documented Lorazepam 0.5 milligrams (mg), give one tablet by mouth/under tongue every day after lunch. Resident #1's July 2024 Medication Administration Record documented Resident #1 was not given the Lorazepam for eight days on July 7, 8, 9, 14, 15, 16, 17, and 18, and documented Resident #1 was given another resident's Lorazepam 0.5 mg for four days on July 10, 11, 12, and 13. On 10/08/2024 at 2:18 PM, the Administrator confirmed Resident #1 was given another resident's Lorazepam 0.5 mg for four days on July 10, 11, 12, and 13 by a Caregiver by mistake thinking it was Resident #1's Lorazepam the facility had been waiting for. Resident #1's Lorazepam medication was not on site from July 7, 2024 through July 18, 2024. On 10/08/2024 at 9:34 AM, the Caregiver verbalized the Caregiver did not know where to find the facility policy or facility form to report and documents incidents. The Caregiver verbalized not knowing if an incident report was available for a medication error incident for Resident #1 and confirmed there was no incident report for the medication error in Resident #1's clinical report. On 10/08/2024 at 2:05 PM, the Administrator confirmed the facility did not have a policy for reporting resident incidents and did not have a form to document incidents. The Administrator confirmed there was no written incident report for the medication error with Resident #1. On 10/08/2024 at 2:18 PM, the Administrator confirmed Resident #1 had been without their Lorazepam medication | | report or be given a reason why no action needs to be taken, and lastly the employees of the facility shall comply with the procedures adopted pursuant to subsection<br><br>2) The Facility Administrator will amend the present Grievance Policy and Complaint Procedures of the facility.<br><br>3) The Facility Administrator will reiterate the facility staff during the scheduled monthly meeting all the Rights of Residents; Procedure for Filing - NAC 449.268 Rights of residents; procedure for filing grievance, complaint or report of incident; investigation and response in accordance with NRS 449.0302.<br><br>4) The Facility Administrator will ensure that the Rights of Residents; Procedure for Filing - NAC 449.268 Rights of residents; procedure for filing grievance, complaint or report of incident; investigation and response are being implemented when issues arise.<br><br>5) The Facility Administrator completed the corrective action | |

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| | from July 7, 2024 until the physician discontinued the Lorazepam on July 18, 2024. Severity: 2 Scope: 3 | | last 10/15/2024 by reviewing the facility policy and create/provide a facility form where to write / report the incidents.<br>6) Please see attached supporting documents: Facility policies and grievance procedures documents which needs to be signed by responsible parties before admission and facility form where to write / report the incidents. | |
| 0871 SS= F | Medication Administration - Plan - NAC 449.2742 and R043-22 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: d) Develop and maintain a plan for managing the administration of medications at the residential facility, including, without limitation: (1) Preventing the use of outdated, damaged or contaminated medications; (2) Managing the medications for each resident in a manner which ensures that any prescription medications, over-the-counter medications and nutritional supplements are ordered, filled and refilled in a timely manner to avoid missed dosages; (3) Verifying that orders for medications have been accurately transcribed in the record of the medication administered to each resident in accordance with NAC 449.2744; (4) Monitoring the administration of medications and the effective use of the records of the medication administered to each resident; (5) Ensuring that each caregiver who administers a medication is | 0871 | **Vista Adult Care LLC**<br><br>**Vista Adult Care I, III Vista Adult Care at Waterfield**<br><br>**1079 Ricco Drive, Sparks, NV 89434**<br><br>**7300 Pahrah Drive, Sparks, NV 89436**<br><br>**3056 Waterfield Drive, Sparks, NV 89434**<br><br>**Telephone No: (775) 338-3886**<br><br>**Fax No. : (775) 360-6000**<br><br>**Website: www.vistaadultcare.com** | 03/11/2025 |

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| | in compliance with the requirements of subsection 6 of NRS 449.037 and NAC 449.196; (6) Ensuring that each caregiver who administers a medication is adequately supervised; (7) Communicating routinely with the prescribing physician, physician assistant or advanced practice registered nurse or other physician, physician assistant or advanced practice registered nurseof the resident concerning issues or observations relating to the administration of the medication; and (8) Maintaining reference materials relating to medications at the residential facility, including, without limitation, a current drug guide or medication handbook, which must not be more than 2 years old or providing access to websites on the Internet which provide reliable information concerning medications. (e) Develop and maintain a training program for caregivers of the residential facility who administer medication to residents, including, without limitation, an initial orientation on the plan for managing medications at the facility for each new caregiver and an annual training update on the plan. The administrator shall maintain documentation concerning the provision of the training program and the attendance of caregivers.<br><br>Inspector Comments: Based on observation and interview, the facility's Administrator failed to implement and maintain a plan for the management of medications and ensure caregivers who administered medications in the facility were oriented and trained on the facility's plan for managing medications. Findings include: On 10/08/2024, the facility lacked a Medication Plan for the facility. On 10/08/2024 at 9:34 AM, the Caregiver was unable to located a Medication Plan for the facility. The Caregiver verbalized the Caregiver did not know if the facility had a Medication Plan. On 10/08/2024 at 2:05 PM, the Administrator could not produce a written facility policy and verbalized the facility did not have a Medication Plan. | | **E-mail:**<br>**vistaadultcare@yahoo.com**<br><br>**MEDICATION PLAN**<br><br>**A Medication Plan prepared in fulfillment of the requirements of the BUREAU OF HEALTH CARE QUALITY**<br><br>**AND COMPLIANCE**<br><br>**By**<br><br>**Evangeline C. Molino**<br><br>**Owner/ Licensed Administrator of Vista Adult Care** | |

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| | Severity: 2 Scope: 3 | | **(1) Prevention of the use of outdated, damaged or contaminated medications:**<br><br>a. All medications including without limitation to over the counter medications should be stored in a locked area that is cool and dry. Dietary supplement must be plainly labeled as its contents, name of resident/s to whom it was prescribed and the name of the prescribing physician.<br><br>b. Medications for external use only must be kept in a locked area separate from other medications.<br><br>c. For residents who are capable of administering their own medication without any supervision, we will keep their medication in their own room but will be placed in a locked container in which we have access to the keys.<br><br>d. The caregivers who are certified to administer the medications will be in charge to check the expiration date of the | |

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| | | | medicine and they will do this every time they administer the medicine.<br><br>e. Medication stored in a refrigerator including without limitation over the counter medication must be kept in a locked box unless the refrigerator is locked or is located in a locked room.<br><br>f. All medicines should be kept in its original container until it is administered.<br><br>g. When a resident is discharged or transferred from a facility, all medications prescribed for the resident must be provided to the resident or to the facility to which he or she is transferred.<br><br>h. If a resident is transferred to a hospital or skilled nursing facility, we shall hold the resident's medication until the resident returns or for thirty days after the transfer whichever is less unless the hospital or skilled nursing facility request us to provide them with the medications. If the resident does not return within 30 days after the transfer, we will dispose all remaining medications using the acceptable methods.<br><br>i. Upon the return of the resident from the hospital or skilled | |

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| | | | nursing facility, we are going to check if there are any changes in the medication. We will contact their physician within 24 hours after the resident returns to clarify the changes and will document the physician contact.<br><br>j. All discontinued and expired medication will be destroyed according to policies like flashing in the toilet or putting inside the zip lock bag<br><br>with sand and put liquid soap and detergent. It will be placed in a double bag and placed inside the big trash bin in front of a witness. The staff who did the destruction and the witness will sign the Medication Destruction Form and the facility will keep the record.<br><br>k. Upon death of the resident, all medications including over the counter medication will be destroyed in front of a witness and sign it by both the destroyer and the witness.<br><br>**(2) Process of Refill on each resident's prescription medications including over the counter drugs and supplement.** | |

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| | | | a. When new residents are admitted in our facility, we made sure that all their medicines are complete. We immediately check with the doctor's order by checking on the medication instruction sheet, count, and log all medicines received and made sure that they are all in the original containers or bubble packs. We review each bottle or bubble pack for the contents, expiration date, and check if all these medications have orders from the doctors. We also check on the refills. If no refills available, we immediately call the physician for the new order. We also set up an appointment with the physician as soon as possible.<br><br>b. We also do the same with the Over the Counter (OTC) medications including dietary supplement. We make sure that OTC medications and dietary supplements are properly labeled with the resident's name and the prescribing physician's name. If there is no physician's order, we immediately contact the doctor's office for orders.<br><br>c. We immediately set up a Medication Administration Record (MAR) for all prescribed medications, Over the Counter | |

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| | | | (OTC), and as needed (PRN) medications with the Physician's order together.<br><br>d. Although most of our residents' prescription is on automatic refill, we have assigned a caregiver who is certified to administer medications in each shift to monitor the medication expiration. We called and check on all medication refills a week before the last dose. Although there are certain medications that cannot be refilled until only 2 days before the last dose because the insurance won't cover it. At least if that would be the last refill, the pharmacist has enough time to fax the authorization to the doctor's office.<br><br>e. Usually if the medication will come from the pharmacy and the refill authorization from the doctor has not been received, we request an emergency refill for at least 2 to 3 days supply which the pharmacy authorized. If the medicine comes from the family, we tried to get them from the family at least 3 to 5 days and we keep on calling until medications are with us. We also advise them to request emergency refill from the pharmacy for 2 to 3 days. In some remote cases when medicine did not arrive | |

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| | | | on time, we document it and send copy to the doctor within 24 hours.<br><br>f. We have the medication arrival log which the authorized care giver filled up upon receipt of the medication. It includes the date medication received, the number of pills received, complete the MAR making sure that the physician's order, the MAR, and the label are all the same.<br><br>g. When residents go out of the facility, we give the family the complete medications needed for the length of time they will be out of the facility. We make sure the family receiving the medicine counted them and signed that they have received the medications with complete instruction on how the medications will be administered. When they come back to the facility, we requested that the family who administered the medication signed the special MAR which we have prepared and noted on the regular MAR that the resident was out of the facility and that medication has been provided to the family.<br><br>**(3) Verification that medication orders have been accurately transcribed to Medication Administration Record (MAR).** | |

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| | | | a. Although all our caregivers are medication certified, we have assigned one caregiver each shift to be responsible to transcribe medication orders onto the MAR each month and each time there is a change to the resident's medication regime. The administrators always check on this every beginning of the month and every time there are changes in the resident's medication orders.<br><br>b. The administrator always checks the MAR three time a week to ensure medication orders are accurate. The caregivers who are certified to administer the medications will be in charge to check the expiration date of the medicine and they will do this every time they administer the medicine.<br><br>**(4) Monitoring of Medication Administration Record (MAR) and the effective use of the MARs for documentation.**<br><br>a. The administrator will do the initial training for the new medication staff. However this new staff will NEVER handle medication until he/she passes the | |

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| | | A. BUILDING _____ B. WING _____ | **10/08/2024** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **VISTA ADULT CARE** | **1079 RICCO DRIVE, SPARKS, NEVADA ,89434** |

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| | | | 16 hours initial medication training with the bureau approved medication trainer.<br><br>b. The administrator is the one responsible for reviewing Medication<br><br>Administration Record (MAR) done by staff. The administrator will review the MAR every first day of the month and 3 times a week thereafter to insure accurate orders are followed.<br><br>c. The facility (Vista Adult Care) will retain all files including the MAR of each resident discharged and passed away for five years.<br><br>**(5) All staff administering medications meets the qualifications set forth in NRS 449.037(6)**<br><br>a. There will be an initial medication training of 12 hours plus 4 hours practical training by a bureau approved medication trainers. The Administrator will provide annual 8 hour training or we can send our staff to an outside source or classes by bureau approved medication trainers. | |

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| | | | b. The facility requires all medication staff to take and pass an annual medication administration examination.<br><br>c. The facility will document all staff training and testing.<br><br>d. The administrator will make sure that she will receive annual training and testing or attend classes and pass the medication examination given by the bureau approved medication trainers so she can train her staff or give them a one on one training to insure successful and accurate Medication Administration Record (MAR).<br><br>**(6) Staff who are responsible for administering medications are adequately supervised.**<br><br>a. The administrator will make sure that the staff administering medication is well supervised to avoid medication oversight. The administrator will make an audit on the MAR 3 times a week to insure the accuracy.<br><br>**(7) Routine communication of issues or observation related to the medication administration to** | |

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| | | | **the prescribing physician or other physician.**<br><br>a. If there will be some concern regarding medication, we usually communicate with the physician by fax, telephone, and e-mail.<br><br>b. Physician's contact information is usually on the resident's file, resident's medication record, and on the master list of all contact information which is posted near the telephone.<br><br>c. The facility is trying to avoid missed dose or sometime the resident refuses medication, but if these things happened, we document it. We send a fax to the resident's physician immediately at least within 24 hours.<br><br>**(8) Maintain reference materials including drug guide or medication hand book that is no more than 2 years old or provide quick access link on line.**<br><br>a. The facility will provide handbook and medication guide to | |

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| | | | the medication staff to insure that they are well informed on current medication issues.<br><br>b. Our handbook and medication guide are kept in an unlock drawer near the Medication Administration Record. The administrator is the one responsible for ordering and providing the staff all medications update.<br><br>c. The caregivers have access to computer and go on line to browse and check the links.<br><br>d. The administrator equips herself with enough outside training so she can administer orientation training to medication administration staff. The facility has an outline on the initial training of the medication staff. It will document all the training to maintain evidence of Continuing Education on Medication.<br><br>- - - - - - - | |
| 0878 SS= D | Medication/OTCS, Supplements, Change Order - NAC 449.2742 and R043-22 - 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 , physician assistant or | 0878 | POC for Tag 0878<br><br>1) The Facility Administrator will ensure that all medications | 10/08/2024 |

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| | advanced practice registered nurse has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician, physician assistant or advanced practice registered nurse. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician, physician assistant or advanced practice registered nurse. 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, physician assistant or advanced practice registered nurse must be administered as prescribed by the physician, physician assistant or advanced practice registered nurse. If a physician, physician assistant or advanced practice registered nurse 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 (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, physician assistant or advanced practice registered nurse 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, physician assistant or advanced practice registered nurse, a 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 | | are on-site to administer as prescribed.<br><br>2)The Facility Administrator will have a monthly reminder to all staff regarding the administration of the medications in accordance with NAC 449.2742 and R043-22.<br>3)The Facility Administrator and the Employee-In-Charge will check weekly the Medication Administration Record to monitor the instructions and the supply of the medications of all residents.<br>4) The Facility Administrator and or the Employee-In-Charge will ensure that Plan of Correction is properly implemented.<br><br>5) The Facility Administrator met and review with the staff especially the topic on "**(2) Process of Refill on each resident's prescription medications including over the counter drugs and supplement " of** the Medication Plan of the facility right away after the inspection left last<br><br>6) 10/08/2024. | |

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| | (b) of subsection 1 of NAC 449.2744.<br><br>Inspector Comments: Based on observation, document review, clinical record review, and interview, the facility failed to 1) administer medication as prescribed for 1 of 5 sampled residents (Resident #1) and 2) ensure medications were on-site to administer as prescribed for 1 of 5 sampled residents (Resident #1). Findings include: Resident #1 Resident #1 was admitted to the facility on 04/15/2024, with diagnoses including non-Hodgkin's lymphoma, chronic encephalopathy, cognitive decline, and weakness. A physician's order dated 05/21/2024, documented Lorazepam 0.5 milligrams (mg), give one tablet by mouth/under tongue every day after lunch. Resident #1's July 2024 Medication Administration Record documented Resident #1 was not given the Lorazepam for eight days on July 7, 8, 9, 14, 15, 16, 17, and 18, and documented Resident #1 was given another resident's Lorazepam 0.5 mg for four days on July 10, 11, 12, and 13. On 10/08/2024 at 2:18 PM, the Administrator confirmed Resident #1 was given another resident's Lorazepam 0.5 mg for four days on July 10, 11, 12, and 13 by a Caregiver by mistake thinking it was Resident #1's Lorazepam the facility had been waiting for. Resident #1's Lorazepam medication was not on site from July 7, 2024 through July 18, 2024. On 10/08/2024 at 2:18 PM, the Administrator confirmed Resident #1 had been without their Lorazepam medication from July 7, 2024 until the physician discontinued the Lorazepam on July 18, 2024. Complaint #NV00071799 and #NV00072166 Severity: 2 Scope: 1 | | | |