Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11924	A. BUILDING _____ B. WING _____	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISTA POINTE AT MIRA LOMA	2520 WIGWAM PARKWAY, HENDERSON, NEVADA ,89074-6182

(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
RFG 0001-Deficiencies	The Statement of Deficiencies was generated as a result of a state licensure survey conducted in your facility, in accordance with Nevada administrative code, chapter 449, and Nevada revised statutes chapter 449- Residential Facility for Groups (RFG), medical facilities and other related entities. The findings and conclusions of any investigation by the Division of Health Care Purchasing and Compliance shall not be construed as prohibiting any criminal civil investigation, actions or other claims for reliefs that may be available to any party under applicable federal, state or local law. Based on an inspection conducted, the items marked below identify the violation in operation of the RFG which must be corrected by the revisit/compliance date specified in writing by the health authority. Failure to comply with this notice and immediately correct the identified deficiencies may result in the suspension or termination of your provider agreement, funding, or future authorization as a provider authorized by the State	RFG 0001-Deficiencies		

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	of Nevada pursuant to NAC 433.384, and other applicable local and state laws. Inspector Comments: This Statement of Deficiencies was generated as a result of an annual survey and a complaint investigation completed in your facility on 05/20/26. The facility is licensed for 138 Residential Facility for Group beds for elderly and disabled persons and/or persons with Alzheimer's disease and Mental Illness which provide assisted living services, Category II residents. The census at the time of survey was 106. Twenty-five resident files and twelve employee files were reviewed. The facility received a grade of A. There was one complaint investigated. Unsubstantiated: 1. Complaint #13708 could not be substantiated. No regulatory deficiencies could be identified. The investigation of Complaint included: Observation of the facility ‘s memory care unit and the courtyard, employee staffing, resident care plan, elopement assessments and fall policy. Interviews were conducted with the Residents, the Wellness Director, receptionist, Medication Technician, and the Administrator. Clinical Record Review of five records. Document Review included facility policy and written facility communication.			

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Y 0255 SS= F	NAC 449.217 6. A residential facility with **more than 10 residents** must: (a) Comply with the standards prescribed in chapter 446 of NAC; and (b) Obtain the necessary permits from the Division. 7. The equipment used for cooking and storing food and for washing dishes in a residential facility with more than 10 residents must be inspected and approved by the Division and the state and local fire safety authorities. Inspector Comments: Based on observation on 05/20/2026, the facility failed to ensure the kitchen and supportive dining services complied with the standards of NAC 446. Findings include: 1. Critical Violations: a. In the reach-in refrigerator, a container of cottage cheese was expired 05/10/26. In the deli prep refrigerator, a container of chicken salad was labeled as prepared on 04/25/26. 2. Major Violations: a. A souffle cup was used as a scoop and stored in a bulk container of oats. A plastic spoon was used as a scoop and stored in a bowl of flour with the spoon handle touching the product. b. Three dietary staff members were not in hair nets or hair restraints while performing various duties in the kitchen at the start of the inspection.	Y 0255	1) Expired cottage cheese and improperly dated chicken salad were immediately discarded. Improper scoops were removed and replaced with approved food -grade scoops stored appropriately. Dietary staff were immediately provided hair restrains and instructed to wearer them at all time while working in food preparation area. Kitchen equipment , hood, microwave, refrigeration units, tables, shelving and floors were thoroughly cleaned. Mattresses, furniture, pallets and construction materials were removed from the dumpster enclosure area. Damaged cabinets in the memory care kitchen were repaired. 2) The Dining Services Director re-educated all dietary staff .Daily sanitation check list implemented. Food storage audit and environmental inspection process was established 3) DSD or designee will conduct kitchen audits 4) DSD or Designee 5) 6/8/2026	06/08/2026

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	c. Multiple non-food contact surfaces of equipment throughout the kitchen were soiled with grease and/or food debris build-up, including: sides of the cook's line equipment; the cook's line ventilation hood; interior of the microwaves; interior of reach-in units; lower shelves, legs and wheels of tables and equipment. d. Mattresses, furniture, wooden pallets, and construction materials were stored on the left side of the dumpster enclosure. e. The floors throughout the kitchen were soiled with food debris and spillage underneath equipment, tables and shelving units. 3. Equipment and Maintenance Violations: a. Multiple cabinets in the memory care kitchen were in disrepair. Severity: 2 Scope: 3			
Y 0876 SS= D	**NAC 449.2742** **Administration of medication: Responsibilities of administrator, caregiver and employees of facility.** 4. Except as otherwise provided in this subsection, a caregiver shall assist in the administration of medication to a resident if the resident needs the caregiver's assistance. A caregiver may assist the ultimate user of: (a) Controlled substances or dangerous drugs only if the conditions prescribed in subsection 6 of NRS 449.0302 are met. (b) Insulin using an auto-injection device only if the conditions prescribed	Y 0876	1) The physician order for resident #16 was reviewed with the physician and clarified. The Medication administration Record was updated to reflect the calefied instructions. 2) Medication Technicians re- educated on identifying and reporting unclear medication orders A medication order review process was implemented to verify physician orders upon receipt 3) The Wellness Director or Designee will audit all new physician orders All unclear orders identified will be clarified immediately with the prescribing practitioner 4) Wellness Director or Designee 5) 6/11/2026	06/11/2026

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	in NRS 449.0304 and section 13 of this regulation are met. Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 25 residents did not require a Medication Technician (Med Tech) to perform a nursing assessment related to blood pressure parameters for medication administration (Resident #16). Findings include: Resident #16 (R16) R16 was admitted on 10/28/25, with diagnoses including metabolic encephalopathy, Sjogren's syndrome, and hypertension. A physician's order dated 02/13/26, and the May 2026 Medication Administration Record (MAR), documented: Losartan 50 milligrams (mg.), take one tablet by mouth every day. Hold if systolic blood pressure was less than 110. The physician's order lacked clarification regarding blood pressure assessment parameters. On 05/20/26 in the morning, the Med Tech reported staff obtained R16's blood pressure and the medication was held if the systolic blood pressure was less than 110. The Med Tech reported they were unaware the physician's order required clarification. Severity: 2 Scope: 1			
Y 0920 SS= D	NAC 449.2748 Medication Storage. 1. Medication including, without limitation, any over-the-counter	Y 0920	1) All unsecured medications and supplements were immediately removed and secured Resident #7 medication storage practices were reviewed, and resident was re-educated regarding safe self administration requirements. Resident #13 medications and supplements were removed.	06/02/2026

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	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 without supervision may keep his medication in his 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. 3. Medication including, without limitation, any over-the-counter-medication or dietary supplement, must be: (a) Plainly labeled as to its contents, the name of the resident for whom it is prescribed and the name of the prescribing physician; and (b) Kept in its original container until it is administered. Inspector Comments: Based on observation and interview, the facility failed to ensure medications were secured in 2 of 25 sampled resident rooms (Resident #7 and #13). Findings include: Resident #7 (R7)		Apartments security and medication storage compliances were verified . 2) Audit of residents rooms completed to identify unsecured medications . Ultimate User Agreements were reviewed to ensure consistency with medication management practices. Staff were re-educated regarding medication storage requirements and room security expectations. 3) Winless Director or designee will perform room audits for medication storage compliance. Any noncompliance will be corrected immediately . 4) Wellness Director or designee 5) 6/2/2026	

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	R7 was admitted on 03/30/24, with diagnoses including osteoporosis and heart disease. R7's Ultimate User Agreement dated 03/08/24, indicated R7 was responsible for self-administering medications. On 05/20/26 in the morning, in R7's apartment, room 111, an unsecured pill-minder container containing medication was observed on the living room end table. R7's apartment door was unsecured and R7 was not present in the apartment. Resident #13 (R13) R13 was admitted on 01/15/21, with diagnoses including chronic kidney disease and chronic obstructive pulmonary disease. R13's Ultimate User Agreement dated 02/07/23, documented the facility was responsible for administering R13's medications. On 05/20/26 in the morning, in R13's apartment, room 160, unsecured Tums, beet supplement, eye drops, Pepto-Bismol, and Metamucil were observed on the kitchen counter and living room end table. R13's apartment door was unsecured and R13 was not present in the apartment. R13 did not have physician orders for the medications. On 05/20/26 in the morning, the Assistant Wellness Director confirmed the unsecured medications and reported R7's apartment door should have been locked and R13 should not have had medications in the apartment. Severity: 2 Scope: 1			
Y 0965 SS= D	NAC 449.2754 Residential facility which provides care to persons with Alzheimer's disease: Application for endorsement; general	Y 0965	1) The alarm exit door was evaluated immediately Alarm volume was adjusted and additional notification device purchased to ensure staff can hear alarms from all areas of the unit Staff were re-educated regarding elopement prevention and response	06/02/2026

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	requirements. 3. The administrator of such a facility shall prescribe and maintain on the premises of the facility a written statement which includes: (a) The facility's policies and procedures for providing care to its residents; (b) Evidence that the facility has established interaction groups within the facility which consist of not more than six residents for each caregiver during those hours when the residents are awake; (c) A description of: (1) The basic services provided for the needs of residents who suffer from dementia; (2) The activities developed for the residents by the members of the staff of the facility; (3) The manner in which behaviors will be managed; (4) The manner in which medication for residents will be managed; (5) The activities that will be developed by the members of the staff of the facility to encourage the involvement of family members in the lives of the residents; and (6) The steps the members of the staff of the facility will take to: (I) Prevent residents from wandering from the facility; and (II) Respond when a resident wanders from the facility; and (d) The criteria for admission to and discharge and transfer from the facility. 4. The written statement required pursuant to subsection 3 must be available for review by residents of the facility, members of the		procedures 2) All exit alarms were tested and evaluated for audibility throughout the unit .Elopement prevention policies and procedures were reviewed with all staff . 3) Any malfunction or audibility concerns will be corrected immediately. 4) Maintenance Director or Designee 5) 6/2/2026	

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	staff of the facility, visitors to the facility and the bureau. 5. The administrator shall ensure that the facility complies with the provisions of the statement required pursuant to subsection 3. Inspector Comments: Based on observation, record review and interview the facility failed to ensure an armed exit door was loud enough to notify staff a resident had eloped from the facility. (Resident #15) Findings include: Resident #15 (R15) R15 was admitted to the facility on 5/13/26 with a diagnosis of Dementia. During a tour of the Memory Care unit with the facility Administrator, all exit doors leading outside to the courtyard were tested. The Administrator had staff open the door where R15 had eloped on 05/15/26, while this surveyor and the Administrator were in the front area of the unit where the Medication Technician was when R15 had eloped. It was identified the alarm did sound but was very hard to hear. On 5/20/26, in the morning the Administrator acknowledged the alarm on the exit door was very hard to hear from the front area of the unit and verbalized they needed to find a way to remedy the situation so staff could hear the exit doors from any area of the unit.			

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	An Incident Report dated 5/15/26 documented R15 eloped from the facility at 8:00 PM. R15 had exited through an armed exit door in the back hallwayof the Memory Care Unit. At the time of the incident the Medication Technician was in the front office of the Memory Care Unit and did not hear the door alarm go off. R15 made it outside to the back of the facility, which was a gated and secured courtyard. Facility staff were unaware R15 had eloped. R15 was seen by a bystander trying to exit out the courtyard gate, and the bystander called 911. Emergency Medical Services (EMS) responded to the community and that was when staff realized R15 had eloped to the outside courtyard. EMS led R15 back into the building as R15 hesitated about coming back inside. EMS assessed R15 for injuries, and no injuries were identified. On 5/20/26 in the morning, the Wellness Director acknowledged R15 eloped out the back alarmed exit door of the facility without staff noticing and R15 was outside alone and was trying to get out of the secured area. Severity 2 Scope 1			