STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295093	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canyon Vista Post Acute	6352 Medical Center Street Las Vegas, NV 89148

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. Based on interview and document review, the facility failed to ensure the Release of Information policy included a defined time frame for providing resident medical records when requested. The deficient practice had the potential to delay access to a resident's medical records.Findings include: A home health agency (HHA) requested medical records on 05/01/2025 for resident 4 (R4). A second request was made on 05/20/2025. Medical records were electronically sent to the HHA on 05/20/2025 and 05/21/2025. On 12/05/2025 at 9:37 AM, the Medical Records Director explained no medical records would not have been released without a request. Once a request was received, staff documented a note in the including details of the portion of the record provided. The Medical Records Director was unsure if other staff had documented the requests. Medical records were usually provided the same day they were requested. The Medical Records Director indicated there were no documented requests for medical records, and no phone calls from a HHA regarding R4. The Medical Records Director confirmed that both the fax machine in the medical records office and the one located in the hallway were shared by all office staff. Fax cover sheets and written requests were kept for 30 days. Review of the facility policy titled Release of Information, dated 11/2009 revealed it lacked documented time frames for processing medical records requests. Complaint 2281170

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, record review, and documentation review, the facility failed to ensure a copy of the discharge medication list and education about the medication was provided for 1 of 6 sampled residents (Resident 5). This failure had the potential to lead to medication errors and adverse drug reactions causing resident harm. Findings include: Resident 5 (R5) was admitted to the facility on [DATE] and discharged on 06/20/2025, with diagnoses including acute respiratory failure, chronic obstructive pulmonary disease, local infection of the skin and subcutaneous tissue, and sepsis. The facility was unable to provide documentation of a discharged medication list or education regarding the medications released to R5 upon discharge. On 12/05/2025 at 9:37AM, the registered nurse indicated residents could ask their pharmacy or call the facility back if they were unsure of their medications or prescriptions after discharge. On 12/05/2025 at 9:54AM, the social services assistant explained it was the nurse's responsibility to review the resident's medications and prescriptions given at discharge. On 12/05/2025 at 12:12PM, the Director of Nursing (DON) acknowledged the nurse was responsible for educating the resident on their discharge instructions, including medications, prescriptions and follow up with their primary care provider. The DON explained the nurse was also responsible for ensuring the resident understood and signed the discharge instructions.On 12/05/2025 at 2:59PM, the former DON conveyed there should have been documentation medications provided to the resident and education given. A facility policy titled Discharge Planning, revised October 2022, indicated health and medical education needs were assessed and coordinated by the nursing department. The Discharge Plan of Care and Discharge Summary packet included a discharge medication list and prescriptions for medication. The nursing department was responsible for completing the discharge instructions with the patient and their representative.