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	04/10/2026

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview record review and document review, the facility failed to ensure:1) medications were not left on a resident's breakfast tray and documented as administered without direct observation of ingestion for 1 of 40 sampled residents (Resident 96);2) medications were not pre-charted as administered prior to actual administration for 1 of 40 sampled residents (Resident 153); and3) nephrostomy care was not documented as completed without actual provision of care for 1 of 40 sampled residents (Resident 77).The deficient practice had the potential to compromise quality of care provided to residents.Findings include:1)Resident 96 (R96) was admitted on [DATE], with diagnoses including transient cerebral ischemic attack and polyneuropathy.On 04/07/2026 at 8:34 AM, R96 sat up in bed eating breakfast, a medication cup containing eight pills was observed on the meal tray. R96 indicated the nurse left it there so R96 could take the medication when they were ready. R96 stated, I know they are busy and I am still eating my breakfast.On 04/07/2026 at 8:37 AM, the Registered Nurse (RN1) assigned to R96 acknowledged leaving the medication cup on R96's meal tray and identified the pills including:Aspirin, Vitamin B complex, Biotin, Carvedilol, Duloxetine, Ezetimibe, Lisinopril, and Multivitamins and minerals.RN1 displayed R96's electronic health record (EHR) and confirmed documenting R96's medications as administered. RN1 indicated the medications should not have been left at bedside and medications must be taken in the nurse's presence prior to being documented as given. RN1 acknowledged this was not the first time doing this for R96 because this was the resident's preference.On 04/07/2026 at 8:45 AM, the Director of Nursing (DON) indicated medications must not be left at bedside and should not have been documented as administered without direct observation of ingestion in accordance with the facility's policy for medication administration including documentation requirements.2)Resident 153 (R153) was admitted on [DATE], with diagnoses including muscle weakness and problems with gait and mobility.On 04/08/2026 at 8:19 AM, a medication pass observation revealed the Registered Nurse (RN2) dispensed R153's routine medications in a medication cup, namely, Vitamin D, Vitamin C, Multivitamins and minerals, Vitamin B12, and Fludrocortisone acetate.RN2 poured 60 milliliters of Med Pass 2.0 into a cup and was observed to click the administered button for each medication in R153's EHR prior to entering R153's room. RN2 acknowledged clicking the administered button before actual administration of the medications.On 04/08/2026 at 8:22 AM, RN2 entered R153's room and explained the medications being given. R153 refused to drink the Med Pass nutritional supplement and took the pills with a sip of water. Once RN2 left the resident's room, R153 was observed spitting out the pills on right hand and stated, my wife said these are not good for me. RN2 was asked to come back to the resident's room and RN2 collected the pills using a piece of tissue.On 04/08/2026 at 8:30 AM, RN2 acknowledged pre-charting R153's medications as administered before medication pass and verbalized, they should not have done so because incidents such as refusals and spitting out could occur resulting in inaccurate recording of actual care given to the residents. RN2 indicated pre-charting went against facility protocol for medication administration.On 04/08/2026 at 9:01 AM, the Director of Nursing (DON) indicated RN1 and RN2 did not follow facility policy for medication administration. RN1 documented R96's medications as administered without direct observation while RN2 pre-charted (continued on next page)

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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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications prior to actual medication pass. The DON indicated this practice resulted in the EHR not aligning with the actual care provided. A Medication Administration Survey Ready document was observed on top of RN2's medication cart. The document instructed nurses, during medication pass, stay until all medications were taken. Chart after giving medication. Never chart before giving the medications.On 04/09/2026 at 10:20 AM, the Regional Director of Clinical Services provided the professional standards of practice from the American Nurses Association (ANA) which revealed accurate documentation was an essential element of safe, quality evidence-based nursing practice which included care provided by nurses. Timely documentation in the EHR should be maintained in the residents' MAR.3)Resident 77 (R77) was admitted on [DATE], with diagnoses including acute kidney failure, chronic kidney disease stage four and artificial openings of urinary tract.On 04/07/2026 at 10:07 AM, a Registered Nurse (RN) turned R77 to their right side which revealed nephrostomy tubes on R77's left and right lower back. The left nephrostomy tube was covered with a white dressing dated 03/30/2026, a small dark green stain was observed at the tubing insertion site. The right nephrostomy site was covered with undated white dressing.A physician order dated 03/01/2026, documented to cleanse the right flank nephrostomy site with normal saline (NS), pat dry, apply drain cover and Tegaderm, every day shift every Mondays and Saturdays and as needed for wet or dislodged dressing.A physician order dated 03/01/2026, documented to cleanse the left flank nephrostomy site with normal saline (NS), pat dry, apply drain cover and Tegaderm, every day shift every Mondays and Saturdays and as needed for wet or dislodged dressing.The medication administration record (MAR) for April 2026, documented a staff member signed off on the cleansing and dressing change for the left and right nephrostomy site on 04/04/2026.On 04/08/2026 at 1:43 PM, the lead wound nurse explained the wound care team was responsible for nephrostomy care in the facility. The lead wound nurse could not speak to why nephrostomy care was signed off by wound care nurse on 04/04/2026 when the dressing was dated 03/30/2026.On 04/08/2026 at 1:53 PM, the lead wound nurse explained the wound care nurse acknowledged signing off on the cleansing and dressing changes to R177's right and left nephrostomy on 04/04/2026 prior to performing the task. The wound care nurse forgot to modify R77's MAR entry when the resident refused care. On 04/08/2026 at 2:00 PM, the lead wound nurse confirmed the wound care nurse inaccurately recorded the care as performed when it was not. On 04/08/2026 at 2:07 PM, the DON indicated the wound care nurse should not have documented the care was performed in R77's MAR without actual providing the care on 04/04/2026.On 04/08/2026 at 2:15 PM, the lead wound nurse stated this practice placed R77 at risk for infection of nephrostomy site.The facility's Medication Administration policy revised April 2019 documented the individual administering the medication would document on the resident's MAR after giving each medication.

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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 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and document review, the facility failed to ensure care orders for nephrostomy tubes were followed for 1 of 40 sampled residents (Resident 77). The deficient practice placed the resident at risk for infection.Findings include: 1)Resident 96 (R96) was admitted on [DATE], with diagnoses including transient cerebral ischemic attack and polyneuropathy.On 04/07/2026 at 8:34 AM, R96 sat up in bed eating breakfast, a medication cup containing eight pills was observed on the meal tray. R96 indicated the nurse left it there so R96 could take the medication when they were ready. R96 stated, I know they are busy and I am still eating my breakfast.On 04/07/2026 at 8:37 AM, the Registered Nurse (RN1) assigned to R96 acknowledged leaving the medication cup on R96's meal tray and identified the pills including:Aspirin, Vitamin B complex, Biotin, Carvedilol, Duloxetine, Ezetimibe, Lisinopril, and Multivitamins and minerals.RN1 displayed R96's electronic health record (EHR) and confirmed documenting R96's medications as administered. RN1 indicated the medications should not have been left at bedside and medications must be taken in the nurse's presence prior to being documented as given. RN1 acknowledged this was not the first time doing this for R96 because this was the resident's preference.On 04/07/2026 at 8:45 AM, the Director of Nursing (DON) indicated medications must not be left at bedside and should not have been documented as administered without direct observation of ingestion in accordance with the facility's policy for medication administration including documentation requirements.2)Resident 153 (R153) was admitted on [DATE], with diagnoses including muscle weakness and problems with gait and mobility.On 04/08/2026 at 8:19 AM, a medication pass observation revealed the Registered Nurse (RN2) dispensed R153's routine medications in a medication cup, namely, Vitamin D, Vitamin C, Multivitamins and minerals, Vitamin B12, and Fludrocortisone acetate.RN2 poured 60 milliliters of Med Pass 2.0 into a cup and was observed to click the administered button for each medication in R153's EHR prior to entering R153's room. RN2 acknowledged clicking the administered button before actual administration of the medications.On 04/08/2026 at 8:22 AM, RN2 entered R153's room and explained the medications being given. R153 refused to drink the Med Pass nutritional supplement and took the pills with a sip of water. Once RN2 left the resident's room, R153 was observed spitting out the pills on right hand and stated, my wife said these are not good for me. RN2 was asked to come back to the resident's room and RN2 collected the pills using a piece of tissue.On 04/08/2026 at 8:30 AM, RN2 acknowledged pre-charting R153's medications as administered before medication pass and verbalized, they should not have done so because incidents such as refusals and spitting out could occur resulting in inaccurate recording of actual care given to the residents. RN2 indicated pre-charting went against facility protocol for medication administration.On 04/08/2026 at 9:01 AM, the Director of Nursing (DON) indicated RN1 and RN2 did not follow facility policy for medication administration. RN1 documented R96's medications as administered without direct observation while RN2 pre-charted medications prior to actual medication pass. The DON indicated this practice resulted in the EHR not aligning with the actual care provided. A Medication Administration Survey Ready document was observed on top of RN2's medication cart. The document instructed nurses, during medication pass, stay until all medications were taken. Chart after giving medication. Never chart before giving the medications.On 04/09/2026 at 10:20 AM, the Regional Director of Clinical Services provided the professional standards of practice from the American Nurses Association (ANA) which revealed accurate documentation was an essential element of safe, quality evidence-based nursing practice which included care provided by nurses. Timely documentation in the EHR should be maintained in the residents' MAR.3)Resident 77 (R77) was admitted on [DATE], with diagnoses including acute kidney failure, chronic kidney disease stage four and artificial openings of urinary tract.On 04/07/2026 at 10:07 AM, a Registered Nurse (RN) turned R77 to their right side which (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed nephrostomy tubes on R77's left and right lower back. The left nephrostomy tube was covered with a white dressing dated 03/30/2026, a small dark green stain was observed at the tubing insertion site. The right nephrostomy site was covered with undated white dressing.A physician order dated 03/01/2026, documented to cleanse the right flank nephrostomy site with normal saline (NS), pat dry, apply drain cover and Tegaderm, every day shift every Mondays and Saturdays and as needed for wet or dislodged dressing.A physician order dated 03/01/2026, documented to cleanse the left flank nephrostomy site with normal saline (NS), pat dry, apply drain cover and Tegaderm, every day shift every Mondays and Saturdays and as needed for wet or dislodged dressing.The medication administration record (MAR) for April 2026, documented a staff member signed off on the cleansing and dressing change for the left and right nephrostomy site on 04/04/2026.On 04/08/2026 at 1:43 PM, the lead wound nurse explained the wound care team was responsible for nephrostomy care in the facility. The lead wound nurse could not speak to why nephrostomy care was signed off by wound care nurse on 04/04/2026 when the dressing was dated 03/30/2026.On 04/08/2026 at 1:53 PM, the lead wound nurse explained the wound care nurse acknowledged signing off on the cleansing and dressing changes to R177's right and left nephrostomy on 04/04/2026 prior to performing the task. The wound care nurse forgot to modify R77's MAR entry when the resident refused care. On 04/08/2026 at 2:00 PM, the lead wound nurse confirmed the wound care nurse inaccurately recorded the care as performed when it was not. On 04/08/2026 at 2:07 PM, the DON indicated the wound care nurse should not have documented the care was performed in R77's MAR without actual providing the care on 04/04/2026.On 04/08/2026 at 2:15 PM, the lead wound nurse stated this practice placed R77 at risk for infection of nephrostomy site.The facility's Medication Administration policy revised April 2019 documented the individual administering the medication would document on the resident's MAR after giving each medication.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to ensure food items were not expired, properly dated, labeled, and discarded as required from the refrigerator for 3 of 4 nourishment rooms inspected. This deficient practice had the potential to result in foodborne illness, affecting the health and safety of residents. Findings include: On 04/07/2026 at 8:30 AM, an inspection of the 400-hall nourishment room refrigerator revealed resident food items with an expiry date of 03/03/2026. On 04/07/2026 at 8:32 AM, an inspection of the 100-hall nourishment room, refrigerator revealed resident food an expiry date of 04/03/2026 and an unlabeled resident food item.On 04/07/2026 at 8:35 AM, an inspection of the hall-200 nourishment room, refrigerator revealed six milk cartons expiry date of 03/05/2026. On 04/07/2026 at 11:47 AM, the Assistant Director of Nursing (ADON), verified the resident food had expired and should have been discarded. The ADON confirmed the additional resident food items did not have a label and expressed that the food items should have been labeled before being placed into refrigerator for proper identification and expiration. On 04/07/2026 at 11:52 AM, a Registered Nurse verified the resident food had expired and should have been discarded per facility policy.On 04/08/2026 at 10:00 AM, a Certified Nursing Assistant (CNA) stated the nursing staff were responsible for labeling resident's food and checking for expiration. The CNA clarified the nourishment refrigerator was checked daily and if the food was expired, staff would notify the residents and discard the food. On 04/08/2026 at 10:20 AM, a Certified Nursing Assistant (CNA) voiced that food in the nourishment room refrigerator must be labeled and dated with an expiration date. The CNA indicated the refrigerator was checked daily by the CNAs and if any food is expired it would be discarded. At 10:47 AM, Director of Dietary, verbalized the nourishment refrigerator was checked twice a day for expired food and drink items and confirmed the resident refrigerator should not have had expired milk cartons inside. The Director of Dietary indicated the milk cartons should have been discarded.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation, interview and document review, the facility failed to ensure the trash compactor was sealed, in good repair, and free of leaks, foul odors, and accumulated liquid waste. The deficient practice created the potential for unsanitary conditions, foul odors and pest infestation. Findings include: On 04/07/2026 at 8:10 AM, an inspection of the facility's kitchen revealed a trash compactor with a foul smell and various leaks that traveled throughout the side and bottom of the trash compactor. On 04/07/2026 at 8:16 AM, the head cook confirmed the compactor had a known leak and verbalized the area needed to be cleaned due to a safety hazard and a present foul odorOn 04/07/2026 at 8:22 AM, the Maintenance Director verified the trash compactor had a leak and confirmed the trash compactor needed to be replaced. On 04/08/2026 at 1:48 PM, the Assistant Director of Nursing (ADON), confirmed the trash compactor was not in sanitary condition and had a leak with a present odor, which would cause a pest concern. The facility policy titled Sanitization (undated) documented, areas used for garbage disposal were free from odors and waste fats and maintained to prevent pest. Garbage and refuse containers were cleaned and in good condition.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and document review, the facility failed to ensure appropriate personal protective equipment (PPE) was available in the laundry room for staff handling soiled linens. This deficient practice had the potential to expose staff and residents to contaminants from soiled linens and increased the risk of transmission of infectious organisms in a facility with active resident infections.Findings include:A Daily Overview Summary Report (undated) listed 18 confirmed, current resident infections in the facility, including Clostridioides difficile (C. diff), wound infections, and cellulitis.On 04/08/2026 at 2:36 PM, an inspection of the laundry room revealed gowns (PPE) were not available for staff use.On 04/08/2026, a laundry aide, confirmed that gowns were not available in the laundry room for staff use. The laundry aide indicated gowns would need to be obtained from another area of the facility and pointed toward the resident room areas and hallways. On 04/06/2026 at 2:26 PM, the Infection Preventionist (IP), confirmed gowns were not available in the laundry room. The IP acknowledged gowns should have been accessible to laundry staff, to protect staff and prevent contamination from soiled or contaminated items. The IP explained the lack of gowns in the laundry room increased the risk of contamination.On 04/20/2026, the Director of Nursing (DON) reported the expectation, per facility policy, was that gowns should have been easily accessible to staff in the laundry room. The DON explained gowns were used in the laundry room to prevent contamination and the spread of infection.A facility policy titled Laundry and Bedding, Soiled, revised September 2022, documented all used laundry was handled as potentially contaminated using standard precautions (for example, gloves and gowns when sorting). Hand hygiene products, gloves and gowns, were available and used while sorting and handling contaminated linens.A facility policy titled Departmental (Environmental Services) - Laundry and Linen (undated), documented employees sorting or washing linen must wear a gown and gloves.