

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER <b>295093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED <b>06/11/2020</b>
NAME OF PROVIDER OF SUPPLIER <b>CANYON VISTA POST ACUTE</b>		STREET ADDRESS, CITY, STATE, ZIP <b>6352 MEDICAL CENTER STREET LAS VEGAS, NV 89148</b>	
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 0880  <b>Level of harm</b> - Minimal harm or potential for actual harm  <b>Residents Affected</b> - Few	<b>Provide and implement an infection prevention and control program.</b>  Based on observation, interview, and document review, the facility failed to ensure an Activities Assistant and a driver wore a mask when around a resident, and a resident wore a mask while ambulating in the hallway. Findings include: On 06/10/2020 at 11:20 AM, an Activities Assistant had a cloth mask pulled down under the chin. The Activities Assistant explained the mask was too big and would slip down to under the chin and confirmed the proper way to wear the mask was covering the nose and mouth. On 06/10/2020 at 11:25 AM, another Activities Assistant explained both the nose and mouth should be covered when wearing a cloth or surgical mask. On 06/10/2020 at 12:10 PM, a Licensed Practical Nurse (LPN) explained both the nose and mouth should be covered when wearing a cloth or surgical mask. On 06/11/2020 at 4:12 PM, a facility driver was observed pushing a resident in a wheelchair from 300 hall to the 100 hall nurses' station without a mask. The Charge Nurse confirmed that the facility driver should have worn a mask. On 06/10/2020 at 8:22 AM, the DON conveyed residents were to wear a mask before leaving their rooms. On 06/10/2020 at 1:30 PM, a resident was observed ambulating towards the 100 hall nurses' station, not wearing a mask. The mask was hanging on the handle of the resident's front-wheel walker. The Charge Nurse indicated the residents were provided a mask or could use a personal mask. The residents must wear a mask before leaving their rooms.		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER  
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) 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.