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 _____	**03/05/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESCALANTE AT THE LAKES	**2620 LAKE SAHARA DRIVE, LAS VEGAS, NEVADA ,89117**

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure and Complaint Investigation survey completed on 03/05/2025, in accordance with Nevada Administrative Code (NAC) Chapter 449, Requirements for Residential Facilities for Groups. The facility is licensed for 150 Residential Facility for Group beds for elderly and disabled persons, with endorsements for Alzheimer's disease and Category II residents. The census at the time of the survey was 44. Sixteen resident files and ten employee files were reviewed. The facility received a grade of C. There was one complaint investigated. Unsubstantiated: Complaint #NV00073253 was ubsubstantiated. The investigation of Complaint included: Observation of resident to resident interactions, medication reviews. Interviews were conducted with residents, Caregivers, Medication Technicians, Wellness Director, and the Administrator. 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 investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | Name: ROBERT SANDERSON | Title: Administrator | Date: 04/07/2025

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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0255 SS= F	Permits-Comply with NAC 446 on Food Service - NAC 449.217 Kitchens; storage of food; adequate supplies of food; permits; inspections. (NRS 449.0302) 6. A residential facility with more than 10 residents shall: (a) Comply with the standards prescribed in chapter 446 of NAC; and (b) Obtain the necessary permits from the Division. Inspector Comments: Based on observation on 03/05/2025, 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 walk-in cooler, two containers of sour cream were expired on 02/12/25; one container was opened on 03/03/25. b. Food products prepared in the facility were held longer than seven days past the date of preparation; in the walk-in cooler, a container of alfredo sauce was prepared on 02/19/25 and a pan of sauerkraut was prepared on 02/25/25. c. There was no detectable level of chlorine sanitizer dispensed during the final rinse cycle at the low temperature dish machine. 2. Major Violations: a. A household grade undercounter refrigerator was installed on a standard table next to the steam table as a replacement to the previous commercial grade reach-in cooler. b. The cook's line ventilation hood filters were soiled with grease build-up and the lower portion of the reach-in unit in the South Memory Care serving kitchen was soiled will spillage. c. The hand sink on the clean side of the dish machine had hot water dispensed at a low pressure. d. The floors in the South Memory Care serving kitchen were soiled with debris and the floor sink was heavily soiled with grime build-up. 3. Equipment and Maintenance Violations: a. The ceiling in the janitor's closet in the main kitchen was in disrepair and there was a large open space in the ceiling around the sprinkler head and exhaust fan. Severity: 2 Scope: 3	0255	1: a&b: On 3/5/25 All items mentioned have been removed and all additional items have been properly labeled. Executive Director and Executive Chef held a training meeting with Dinning staff regarding labeling items properly and making sure nothing is held longer than 7 days times. C. On 3/5/25, Eco lab came to our community immediately when notified that our Chlorine Sanitizer wasn't being dispensed properly. Eco lab fixed the issues, conducted a new test and the Chlorine Sanitizer was now being dispensed properly. 2. A: On 3/6/25 Refrigerator has been removed and no longer in use in any part of the community. Going forward, Executive Director and Executive Chef will ensure all appliances in Kitchen is commercial grade. B: On 3/7/25 All cook ventilation hood filters have been cleaned. C. on 3/10/25 sink next to dishwasher in main kitchen was fixed. D. On 3/6 kitchen floors in South MC have been deep cleaned and all debris has been removed. 3a: On 3/11/25 Ceiling has been fixed/repaired in the Janitors closet	03/11/2025

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0503 SS= D	Written Policies - Compliance with - NAC 449.258 Written policies for facility; policy on visiting hours; residents ' mail; compliance with policies. (NRS 449.0302) 4. The employees of the facility shall comply with the policies developed pursuant to this section. Inspector Comments: Based on interview, record review, and document review, the facility failed to comply with their established policy and procedure regarding medication availability for 1 of 16 residents. (Resident #9) Findings include: Resident #9 (R9) R9 was admitted to the facility on 11/27/24 with a diagnosis of Alzheimer's. On 03/05/25 in the morning, Quetiapine was not on site for R9. A physician's order dated 01/03/25 documented Quetiapine 25 milligram (mg) tablet, take one tablet by mouth 3 times daily for agitation. The March 2025 Medication Administration Record (MAR) documented Quetiapine 25 milligram (mg) tablet, take one tablet by mouth 3 times daily for agitation. On 03/05/25 in the morning, the Med Tech acknowledged the Quetiapine was not onsite and verbalized the medication was on order. A medication packing slip referencing R9's medication Quetiapine, was emailed to the surveyor on 03/06/25. The packing slip documented 3 bottles of Quetiapine arrived at the facility and was available for R9 on 03/06/25, 24 hours after the Med Tech indicated an order was submitted. Facility Medication Availability Policy dated 06/20/24 documented at any time when a medication is not available when needed the Resident Care Coordinator is to be notified immediately. If the Resident Care Coordinator cannot ensure the medication will be delivered to the community within 4 hours, the Executive Director will be notified for further action. Staff are to document all attempts made and actions taken to obtain medication. Severity: 2 Scope: 1	0503	HSD, Regional Nurse and ED will be reviewing all medications for residents on a weekly basis going forward. Any and all missed meds will be documented. Any missing medications will be documented and pharmacy will be conducted. HSD has conducted a training with all med techs to ensure they are aware of the proper protocols when a medication is missing and or near a refill.	03/06/2025

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0620 SS= D	Written Policy on Admissions - NAC 449.2702 and R043-22 Written policy on admissions; eligibility for residency. (NRS 449.0302) 4. Except as otherwise provided in NAC 449.275, a residential facility shall not admit or allow to remain in the facility any person who: (a) Is bedfast; (b) Requires restraint; (c) Requires confinement in locked quarters; or (d) Requires skilled nursing or other medical supervision on a 24-hour basis. Inspector Comments: Based on observation, interview and record review, the facility failed to obtain a waiver to maintain residents who were bedfast, for 2 of 15 residents (Resident #6 and Resident #13). Findings include: Resident #6 (R6) R6 was admitted on 03/29/24 with diagnosis including type 2 diabetes mellitus and right and left heels cellulitis. On 03/05/25, in the morning, a caregiver indicated R6 could not turn in bed without staff assistance. Review of R6's medical record lacked documentation a bedfast waiver was obtained. Resident #13 (R13) R13 was admitted on 04/25/22 with diagnosis including Alzheimer's disease and hypertension. On 03/05/25, in the morning, R13 was observed in bed and did not respond to request to turn on their side. On 03/05/25, in the morning, a Caregiver indicated R13 could not turn on their side without staff assistance. Review of R13's medical record lacked documentation a bedfast waiver was obtained. On 03/05/25, in the morning, the Wellness Director revealed they did not know if a bedfast waiver was obtained for R6 and R13 and confirmed there were no bedfast waivers in R6's and R13's medical records. Severity: 2 Scope: 1	0620	On March 18th we obtain a bed fast waiver for R13. On March 20th we received a bed fast waiver for R15. HSD and ED will make sure going forward that a bedfast waiver will be requested within 24 hours when there is a change in condition for our residents. **On a side note It states a bedfast waiver for R6 but that is incorrect. It should be R13 instead. R6 is fairly mobile and is not in bed all day nor has any wounds.	03/20/2025

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0830 SS= D	Exemption Requests - NAC 449.2736 Procedure to exempt certain residents from restrictions. (NRS 449.0302) 1. The administrator of a residential facility may submit to the Division a written request for permission to admit or retain a resident who is prohibited from being admitted to a residential facility or remaining as a resident of the facility pursuant to NAC 449.271 to 449.2734, inclusive. Inspector Comments: Based on interview and record review, the facility failed to obtain a waiver to maintain residents who had wounds, for 2 of 15 residents (Resident #6 and Resident #13). Findings include: Resident #6 (R6) R6 was admitted on 03/29/24 with diagnosis including type 2 diabetes mellitus and right and left heels cellulitis. Review of R6's physical exam, dated 04/18/24, revealed R6 had cellulitis and gangrene on both heels. Review of R6's medical record did not document a wound waiver for R6. Resident #13 (R13) R13 was admitted on 04/25/22 with diagnosis including Alzheimer's disease and hypertension. Review of R13's physical exam, dated 09/17/23, revealed R13 had a stage IV pressure sore to the coccyx. Review of R13's medical record did not document a wound waiver for R13. On 03/05/25, in the morning, the Wellness Director revealed they did not know if a wound waiver was obtained for R6 and R13 and confirmed there were no wound waivers in R6's and R13's medical records. Severity: 2 Scope: 1	0830	On March 18th we obtain a bed fast waiver for R13. On March 20th we received a bed fast waiver for R15. HSD and ED will make sure going forward that a bedfast waiver will be requested within 24 hours when there is a change in condition for our residents. **On a side note It states a bedfast waiver for R6 but that is incorrect. It should be R13 instead. R6 is fairly mobile and is not in bed all day nor has any wounds.	03/20/2025
0870 SS= F	Medication Administration-Accuracy & Report - NAC 449.2742 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: (a) Ensure that a physician, pharmacist or registered nurse who does not have a financial interest in the facility: (1) Reviews	0870	On 3/6/25 HSD and ED conducted a thorough search of our records and were unable to locate the documentation. To ensure compliance and transparency in the future, the HSD and ED will be working to review our processes and verify if the review is completed but not properly archived. Additionally, we are implementing measures to strengthen our record keeping practices to prevent similar occurrences in	03/06/2025

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	for accuracy and appropriateness, at least once every 6 months the regimen of drugs taken by each resident of the facility, including, without limitation, any over-the-counter medications and dietary supplements taken by a resident; and (2) Provides a written report of that review to the administrator of the facility. (b) Include a copy of each report submitted to the administrator pursuant to paragraph (a) in the file maintained pursuant to NAC 449.2749 for the resident who is the subject of the report. (c) Make and maintain a report of any actions that are taken by the caregivers employed by the facility in response to a report submitted pursuant to paragraph (a). Inspector Comments: Based on interview and record review, the facility failed to ensure a medication regimen review was completed every six months for 6 of 15 residents. (Resident #6, #7, #8, #10, #14, and #15) Findings include: Resident #6 (R6) R6 was admitted to the facility on 03/29/24, with a diagnosis of diabetes. R6's file lacked documented evidence a medication review was completed since R6's admission. Resident #7 (R7) R7 was admitted on 12/31/23 with diagnosis including chronic obstructive pulmonary disorder and dementia. Review of R7's medical record revealed a medication review was last completed on 08/02/24. There was no documentation a medication review was completed for R7 six months after the last one. Resident #8 (R8) R8 was admitted to the facility on 11/23/22, with a diagnosis of dementia. R8's file lacked documented evidence a medication review was completed since R8's admission. Resident #10 (R10) R10 was admitted to the facility on 09/14/23, with a diagnosis of encephalopathy. R10's file lacked documented evidence a medication review was completed since R10's admission. Resident #14 (R14) R14 was admitted to the facility on 04/01/23, with a diagnosis of		the future. **We will contact new pharmacy to request immediate audit due to being unable to get old reports from previous pharmacy since December of 24 transition. We will implement weekly chart audits by HSD with binder to be kept in office for ED review.	

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	diabetes. R14's file lacked documented evidence a medication review was completed since R14's admission. Resident #15 (R15) R15 was admitted to the facility on 05/11/21, with a diagnosis of dementia. R15's file lacked documented evidence a medication review was completed since R15's admission. On 3/5/2025 in the afternoon, the Administrator was notified of the lack of documentation of a medication review for the residents' medication. The Administrator acknowledged the lack of medication reviews every 6 months. Severity: 2 Scope: 3			
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 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	0878	HSD, Regional Nurse and ED will be reviewing all medications for residents on a weekly basis going forward. Any and all missed meds will be documented. Any missing medications will be documented and pharmacy will be conducted. HSD has conducted a training with all med techs to ensure they are aware of the proper protocols when a medication is missing and or near a refill.	03/06/2025

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	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 (b) of subsection 1 of NAC 449.2744. Inspector Comments: Based on observation, interview, and record review, the facility failed to ensure a medication was onsite and available to be administered per physician's order and per the facility policy for 2 of 16 residents (Resident #2 and #9). Findings include: Resident #2 (R2) R2 was admitted to the facility on 06/05/24 with diagnoses including diabetes and hypertension. On 03/05/25 in the afternoon, Buspirone was not on site for R2. A physician's order dated 08/13/24 documented Buspirone 10 milligram (mg) tablet, take one tablet by mouth 2 times daily. The March 2025 Medication Administration Record (MAR) documented Buspirone HCl 10 milligram (mg) tablet, take one tablet by mouth 2 times daily. The medication was documented as not being administered at 8:00 AM and 8:00 PM on 03/01/25, 8:00 PM on 03/02/25, 8:00 AM and 8:00 PM on 03/03/25, 8:00 AM on 03/04/25 and 8:00 AM on 03/05/25 due to the facility waiting for the pharmacy			

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	delivery. On 03/05/25 in the afternoon, the Medication Technician (Med Tech) acknowledged the Buspirone was not onsite and verbalized it had not been administered as prescribed due to the facility waiting for the pharmacy delivery. Resident #9 (R9) R9 was admitted to the facility on 11/27/24 with a diagnosis of Alzheimer's. On 03/05/25 in the morning, Quetiapine was not on site for R9. A physician's order dated 01/03/25 documented Quetiapine 25 milligram (mg) tablet, take one tablet by mouth 3 times daily for agitation. The March 2025 Medication Administration Record (MAR) documented Quetiapine 25 milligram (mg) tablet, take one tablet by mouth 3 times daily for agitation. On 03/05/25 in the morning, the Med Tech acknowledged the Quetiapine was not onsite and verbalized the medication was on order. A medication packing slip referencing R9's medication Quetiapine, was emailed to the surveyor on 03/06/25. The packing slip documented 3 bottles of Quetiapine arrived at the facility and was available for R9 on 03/06/25, 24 hours after the Med Tech indicated an order was submitted. Record Review lacked documented evidence the medication was delivered to the facility and available to R9 within 4 hours of the order, per the facility policy. Facility Medication Availability Policy dated 06/20/24 documented at any time when a medication is not available when needed the Resident Care Coordinator is to be notified immediately. If the Resident Care Coordinator cannot ensure the medication will be delivered to the community within 4 hours, the Executive Director will be notified for further action. Staff are to document all attempts made and actions taken to obtain medication. Severity: 2 Scope: 1			
0936 SS= D	Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be maintained for each resident of a residential	0936	All missing TB test have been attached. ED and HSD will ensure all TB test are obtained upon move in and updated every year after that.	03/19/2025

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	facility and retained for at least 5 years after he or she permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including, without limitation: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. Inspector Comments: Based on interview and record review, the facility failed to ensure 1) a two-step tuberculosis (TB) test was completed for 1 of 16 sampled residents (Resident #2) and 2) an annual TB test was completed for 2 of 16 sampled residents (Resident #3, & #12) Findings include: Resident #2 (R2) R2 was admitted to the facility on 04/29/24 with diagnoses including diabetes and hypertension. R2's file lacked documented evidence of a completed two-step TB test upon admission. Resident #3 (R3) R3 was admitted to the facility on 02/10/25 with a diagnosis of left sided hemiparesis. R3's file documented an initial TB test dated 01/23/25 with a negative reading. R3's record lacked documented evidence of an annual TB test. Resident #12 (R12) R12 was admitted to the facility on 04/27/2022 with a diagnosis of dementia. R12's file documented an initial TB test dated 04/16/2022 with a negative reading. R12's record lacked documented evidence of an annual TB test. On 03/05/2025 in the morning, the Administrator indicated a two-step TB test was required at the time of admission and annually thereafter for residents. The Administrator acknowledged R2 had not completed a two-step TB test and R3, and R12 had not completed an annual TB test, per the requirement. Severity: 2 Scope: 1			

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0991 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 and R043-22 Residential facility which provides care to persons with Alzheimer ' s disease: Standards for safety; personnel required; training for employees. (NRS 449.0302) 1. The administrator of a residential facility which provides care to persons with Alzheimer ' s disease or other forms of dementia who meet the criteria prescribed in paragraph (a) of subsection 2 of NRS 449.1845 shall ensure that: (b) Operational alarms, buzzers, horns or other technology for notifying staff when a door is opened are installed on all doors that may be used to exit the facility. Inspector Comments: Based on observation and interview, the facility failed to ensure an audible alarm and door was in working condition on the exit door of the patio located in the memory care unit. Findings include: On 03/05/2025 at 9:22 AM, while conducting a tour of the facility the door located on the outside patio of the memory care unit leading to the outside of the facility was unlocked and the alarm was not in working condition. On 03/05/2025 at 9:23 AM, the Sales Director acknowledged the door leading to the outside of the facility on the patio located in the memory unit was opening freely and the alarm was not in working condition. On 03/05/2025 at 9:34 AM, the Administrator and Assistant Maintenance Director acknowledged the door leading to the outside of the facility on the patio located in the memory unit was opening freely and the alarm was not in working condition and should have been addressed. Severity : 2 Scope: 3	0991	on 3/5/25, Maintenance Director put lock on door. Code was given to staff members and in-service was given. ABS was contacted to give a quote on repair/ fix the door. This will be completed by 4/15/25 and then temporary lock will be removed. Going forward, Maintenance Director and Executive Director will check door daily to insure it is working properly.	03/05/2025
1600 SS= C	Preferred Name/Pronoun P& P - NAC 449.011943 Policies concerning preferred names and pronouns; adaptation of records to reflect gender identities or expressions; method to obtain medically relevant information from patients or residents. (NRS 449.0302, 449.104) 1. A facility shall: (a) Develop policies to ensure that a patient or	1600	On 3/5/25 the ED and BOM revised our new move in paperwork to include what the prospects preferred pronouns are. Going forward this form will be in all new move in paperwork.	03/05/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**03/05/2025**

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	resident is addressed by his or her preferred name and pronoun and in accordance with his or her gender identity or expression; and (b) To the extent practicable and available within the systems in use at the facility: (1)Adapt electronic records and any paper records the facility uses to reflect the preferred name, pronoun and gender identity or expression of a patient or resident; and (2) Integrate information concerning gender identity or expression into electronic systems for maintaining health records. 2. If a patient or resident chooses to provide the following information, the records adapted pursuant to subparagraph (1) of paragraph (b) of subsection 1 must to the extent required by subsection 1, include, without limitation: (a) The preferred name and pronoun of the patient or resident; (b) The gender identity or expression of the patient or resident; (c) The gender identity or expression of the patient or resident that was assigned at the birth of the patient or resident; (d) The sexual orientation of the patient or resident; and (e) If the gender identity or expression of the patient or resident is different than the gender identity or expression of the patient or resident that was assigned at the birth of the patient or resident: (1) A history of the gender transition and current anatomy of the patient or resident; and (2) An organ inventory for the patient or resident which includes, without limitation, the organs: (I) Present or expected to be present at the birth of the patient or resident; (II) Hormonally enhanced or developed in the patient or resident; and (III) Surgically removed, enhanced, altered or constructed in the patient or resident. Inspector Comments: Based on record review and interview, the facility failed to ensure 15 of 15 residents files included documentation of preferred name, pronoun, and gender expression. Findings include: Review of 15 of 15 resident files revealed the facility did not adapt written records to			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	reflect residents' preferred name, pronoun, and gender expression. On 03/05/25 in the afternoon, the Administrator acknowledged resident records were not adapted to reflect preferred name, pronoun, and gender expression. Severity: 1 Scope: 3			