STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5232	A. BUILDING _____ B. WING _____	01/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADES OF THE SIERRA	275 NEIGHBORHOOD WAY, SPARKS, NEVADA ,89441

(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
0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 01/05/23, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 150 beds; 120 Residential Facility for Group beds, assisted living services for elderly and disabled persons, and 30 Residential Facility for Group beds for persons with Alzheimer's disease, Category II residents. The census at the time of the survey was 72. 15 resident records and 20 employee records were reviewed. The facility received a grade of D. NAC 449.27706 Resurvey: Application and fee; failure to comply. 2. If the Bureau issues a placard to a residential facility that includes a grade of "C" or "D," the administrator must submit an application to the Bureau for a resurvey of the facility not later than 30 days after the facility receives the placard. The fee for an application for a resurvey is $600 and must accompany the application. 3. The Bureau may revoke the license of a residential facility that is required to submit an application for a resurvey pursuant to subsection 2 if the facility fails to submit the application in accordance with the provisions of that subsection. 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		
0106 SS= F	Personnel File - 1st Aid & CPR - NAC 449.200 Personnel files 2. The personnel file for a caregiver of a residential facility must include, in addition to the information required pursuant to subsection 1: (a) A certificate stating that the caregiver is currently certified to perform first aid and cardiopulmonary resuscitation; Inspector Comments: Based on record review and interview, the facility failed to	0106	1. All associate files have been reviewed and entered into an audit tool. 2. An audit tool has been implemented to monitor compliance with regulatory requirements. All associates not in compliance will be removed from the schedule until compliance is met. 3. Audit to be completed by the Business Office and reviewed with	03/01/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5232	A. BUILDING _____ B. WING _____	01/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADES OF THE SIERRA	275 NEIGHBORHOOD WAY, SPARKS, NEVADA ,89441

(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
	ensure employees obtained first aid and cardiopulmonary resuscitation (CPR) training for 10 of 20 sampled employees (Employee #1, #5, #7, #9, #12, #13, #14, #17, #19, and #20). Findings include: Employee #1 Employee #1 was hired as Nurse with a start date of 04/11/17. Employee #1's employee file contained a first aid and CPR training certificate dated 08/05/20 and a first aid and CPR training certificate dated 10/11/22, 67 days beyond the two-year expiration date. Employee #5 Employee #5 was hired as Housekeeper with a start date of 10/16/12. Employee #5's employee file contained a first aid and CPR training certificate dated 07/21/20 and a first aid and CPR training certificate dated 09/10/22, 51 days beyond the two-year expiration date. Employee #7 Employee #7 was hired as Life Enrichment Associate with a start date of 08/06/21. Employee #7's employee file contained a first aid and CPR training certificate dated 11/12/21, 68 days beyond the 30-day requirement. Employee #9 Employee #9 was hired as Life Enrichment Director with a start date of 08/19/20. Employee #9's employee file contained a first aid and CPR training certificate dated 10/15/22, 757 days beyond the 30-day requirement. Employee #12 Employee #12 was hired as Concierge with a start date of 07/09/22. Employee #12's employee file lacked a first aid and CPR training certificate, 150 days beyond the 30-day requirement. Employee #13 Employee #13 was hired as Care Associate with a start date of 05/31/22. Employee #13's employee file contained a first aid and CPR training certificate dated 10/19/22, 111 days beyond the 30-day requirement. Employee #14 Employee #14 was hired as Medication Technician with a start date of 11/18/22. Employee #14's employee file lacked a first aid and CPR training certificate, 18 days beyond the 30-day requirement. Employee #17 Employee #17 was hired as Medication Technician with a start date of 08/15/22. Employee #17's employee file contained a first aid and CPR training certificate dated 10/19/22, 35 days beyond the 30-day requirement. Employee #19 Employee #19 was hired as Plant Operations Director with a start date of 11/01/22. Employee #19's		the Executive Director monthly. 4. Audit to be completed by the Business Office and reviewed with the Executive Director monthly. 5. March 1, 2023. 6. Audit tool attached.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5232	A. BUILDING _____ B. WING _____	01/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADES OF THE SIERRA	**275 NEIGHBORHOOD WAY, SPARKS, NEVADA ,89441**

(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
	employee file lacked a first aid and CPR training certificate, 35 days beyond the 30-day requirement. Employee #20 Employee #20 was hired as Nurse with a start date of 10/21/18. Employee #20's employee file contained a first aid and CPR training certificate dated 01/24/20 expired 01/25/22. Employee #20 was 345 days beyond the two-year expiration date of the most recent certification. On 01/05/23 at 2:25 PM, the Corporate Executive Director provided the Attestation of Compliance form, signed and dated 01/05/23, confirming the Corporate Executive Director had conducted a thorough review of the personnel records to determine compliance and any noncompliance found. The Corporate Executive Director verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. Severity: 2 Scope: 3			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5232	A. BUILDING _____ B. WING _____	01/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADES OF THE SIERRA	275 NEIGHBORHOOD WAY, SPARKS, NEVADA ,89441

(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
0160 SS= C	Advertising - NAC 449.205 Advertising and promotional materials. (NRS 449.0302) Advertising and promotional materials for a residential facility must be accurate and not misrepresent accommodations, services or programs offered by the facility. Inspector Comments: Based on document review and interview, the facility failed to ensure promotional language on the facility's website and internal job descriptions were accurate and did not misrepresent services offered by the facility. Findings include: A review of the facility's promotional website revealed, on the memory care page, the facility offered, "Specially trained nurses manage and coordinate health care needs." The Wellness Director job description, signed by the Wellness Director on 10/05/20, contained, "Perform skilled nursing procedures in compliance with Cascade Living Group policy and the scope of practice of a licensed nurse for care setting." The facility provided a job description signed by the Wellness Director and dated 05/01/21 titled, "Licensed Nurse Job Description." The job description contained a Nature and Scope, "Provides medication management and skilled nursing procedures for residents in compliance with state regulations and scope of practice as defined by state nursing regulatory agency." The staff referred to the Wellness Director as "Nurse" plus first name. On 12/05/23 at 2:28 PM, the Interim Executive Director (IED) was unaware the facility could not have a nurse advertised. The IED verbalized the Wellness Director supervised medication technicians and caregivers and communicated with residents and physicians. On 12/05/23 at 4:00 PM, the Wellness Director verbalized the job description was a corporate document and confirmed the signature on the job description was theirs. Severity: 1 Scope: 3	0160	1. Marketing materials have been updated to remove the word "nursing" to the best that we have been able to locate that term. The job descriptions we are unable to change as we do have a CLIA license requiring a licensed nurse to complete some skills for example COVID testing. 2. Ongoing review of marketing materials to ensure they are representative of a non-medical model of service. 3. Materials will be monitored by the Director of Sales of Marketing under the direction of the Executive Director. 4. Director of Sales and Marketing under the direction of the Executive Director 5. All material changes were submitted in February and changes are rolling out with reprints.	03/15/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5232	A. BUILDING _____ B. WING _____	01/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADES OF THE SIERRA	275 NEIGHBORHOOD WAY, SPARKS, NEVADA ,89441

(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
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 1/5/23, the facility failed to ensure the kitchen and supportive dining services complied with the standards of NAC 446. Findings include: 1. Critical Violations: a. Multiple expired observed in the walk-in refrigerator (Au jus 12/22/22; Hamburger 12/18/22; Salami 12/13/22; Cooked Beef 12/21/22; Ham 12/27/22. In addition, multiple unlabeled, undated, and potentially expired foods were observed in the walk-in refrigerator (rice, chili, prepared sauces, sliced deli meats, hamburger patties). b. A low boy hot holding unit was at 95 degrees F. with potentially hazardous food stored inside at the time of inspection. c. No staff were observed washing hands during the time of inspection. Staff were observed entering and exiting the kitchen operations during this time. d. The three compartment sink quat sanitizer was not detectable. The quat sanitizer container was empty. In addition, there was no detectable sanitizer in multiple quat sanitizer wiping cloth storage buckets. 2. Major Violations: a. There was no soap or paper towels at two separate kitchen handwashing sinks. b. Multiple kitchen cutting boards were stained and worn. c. The cook's line grease fryer and stove were heavily soiled with grease. d. The floors under mounted equipment were no maintained clean. This included areas such as the service line soda dispensers and cook's line. Severity: 2 Scope: 3	0255	1. The following corrections have been made to remedy the deficiencies noted... • Dining services director removed all items that were not labeled or may have expired from the kitchen • Low boy was fixed on the day of the survey • Handwashing stations were restocked on the day of the survey • Three compartment sink was replenished with sanitizer on the day of the survey • All cutting boards have been discarded and replaced. • Complete clean up of kitchen, equipment, walls. Floors and food vents have been cleaned, disinfected and are free of grease and debris. Coca Cola has been out to fix leaking soda fountain and placed parts and cleaned dispenser • 2. Cleaning schedules are being created to ensure these areas are checked daily, weekly or monthly to ensure this does not reoccur. Training has been scheduled to review handwashing and proper use of sanitizer. • 3. Dining services director, Executive Director and/or designee will monitor fo rcompliance. • 4. Dining services director under the supervision of the Executive Director • 5. All corrective actions have been completed, training to be completed by 3/15/23.	03/15/2023
0620 SS= F	Written Policy on Admissions - NAC 449.2702 Written policy on admissions; eligibility for residency. (NRS 449.0302) 4. Except as otherwise provided in NAC 449.275 and 449.2754, a residential facility shall not admit or allow to remain in the facility any person who: (a) Is bedfast; (b)	0620	1. All resident files were reviewed for compliance with Bedfast waiver requirements in conjunction with the current interpretation of the requirements. 2. Going forward the current interpretation will be utilized when	03/10/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5232	A. BUILDING _____ B. WING _____	01/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADES OF THE SIERRA	275 NEIGHBORHOOD WAY, SPARKS, NEVADA ,89441

(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
	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 interview and document review, the facility failed to ensure a resident on hospice care was not allowed to admit or remain in the facility for 11 of 11 residents on hospice (Resident #8, #11, #12, #14, #15, #16, #17, #18, #19, #20, and #21). Findings include: Resident #8 Resident #8 was admitted to the facility on 08/10/22, with diagnoses including essential hypertension, hypothyroidism, and hyperlipidemia. Resident #11 Resident #11 was admitted to the facility on 10/26/22, with diagnoses including unspecified dementia and major depressive disorder. Resident #12 Resident #12 was admitted to the facility on 12/28/21, with diagnoses including dementia and dysphagia. Resident #14 Resident #14 was admitted to the facility on 02/04/19, with diagnoses including dementia, adult failure to thrive, and glaucoma. Resident #15 Resident #15 was admitted to the facility on 10/26/20, with diagnoses including anemia, osteoarthritis and repeated falls. Resident #16 Resident #16 was admitted to the facilty on 05/09/12, with diagnoses including Non-Hodgkin lymphoma and malignant melanoma of the skin. Resident #17 Resident #17 was admitted to the faciltiy on 10/14/21, with diagnoses including aural vertigo, and age-related physical debility. Resident #18 Resident #18 was admitted to the facility on 06/27/20, with diagnoses including vascular dementia, and benign prostactic hyperplasia. Resident #19 Resident #19 was admitted to the facility on 02/25/21, with diagnoses including Alzheimer's disease and bradycardia. Resident #20 Resident #20 was admitted to the facility on 07/13/22, with diagnoses including Parkinson's disease and cerebral atherosclerosis. Resident #21 Resident #21 was admitted to the faciltiy on 06/22/21, with diagnosis including cerebral atherosclerosis and chronic pain. On 01/05/23 at 2:05 PM, the Wellness Director confirmed Resident #8, #11, #12, #14, #15, #16, #17, #18, #19, #20, and #21were receiving hospice care		determining need for a waiver request. 3. Monthly review of residents both on current waivers as well as not on waivers to review change in condition. 4. Resident review will be completed by Wellness Director and the Administrator. 5. All current waiver requests will be submitted by 3/10/23.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5232	A. BUILDING _____ B. WING _____	01/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADES OF THE SIERRA	275 NEIGHBORHOOD WAY, SPARKS, NEVADA ,89441

(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
	from an outside hospice agency. The Wellness Director verbalized the facility had not obtained a waiver for approval to retain residents in need of skilled nursing, nor was the Wellness Director aware the facility needed a waiver to allow a resident on hospice care to be admitted or retained at the facility. Severity: 2 Scope: 3			
0644 SS= C	Posting Requirements - 1. A person who operates a residential facility for groups shall: (a)?Post his or her license to operate the residential facility for groups; (b)?Post the rates for services provided by the residential facility for groups; and (c)?Post contact information for the administrator and the designated representative of the owner or operator of the facility, in a conspicuous place in the residential facility for groups. Inspector Comments: Based on observation and interview, the facility failed to ensure the service rates were posted in a conspicuous place. Findings include: On 01/05/23 at 11:48 AM, the facility rates were not posted in a conspicuous place. On 01/05/23 at 11:52 AM, the Interim Executive Director (IED) verbalized the rates had just been changed and the new rates had not been placed conspicuously yet. The IED verbalized the rates were usually placed in a conference room, not where they would be seen by the public. Severity: 1 Scope: 3	0644	1. All mandatory postings are in the current posting location in the Independent Lobby as requested by the survey team. 2. This item will be added to the weekly manager on duty checklist. 3. The surveillance of the mandatory postings will be added to the weekly manager on duty checklist to ensure the location of the items. 4. Manager on duty will check weekly under the direction of the Executive Director. 5. March 1, 2023. 6. Photo of location attached.	03/01/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5232	A. BUILDING _____ B. WING _____	01/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADES OF THE SIERRA	275 NEIGHBORHOOD WAY, SPARKS, NEVADA ,89441

(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
0690 SS= D	Residents Requiring Use of Oxygen - NAC 449.2712 Residents requiring use of oxygen. (NRS 449.0302) 1. A person who requires the use of oxygen must not be admitted to a residential facility or be permitted to remain as a resident of a residential facility unless he or she: (a) Is mentally and physically capable of operating the equipment that provides the oxygen; or (b) Is capable of: (1) Determining his or her need for oxygen; and (2) Administering the oxygen to himself or herself with assistance. 2. The caregivers employed by a residential facility with a resident who requires the use of oxygen shall: (a) Monitor the ability of the resident to operate the equipment in accordance with the orders of a physician; and (b) Ensure that: (1) The resident ' s physician evaluates periodically the condition of the resident which necessitates his or her use of oxygen; (2) Signs which prohibit smoking and notify persons that oxygen is in use are posted in areas of the facility in which oxygen is in use or is being stored; (3) Persons do not smoke in those areas where smoking is prohibited; (4) All electrical equipment is inspected for defects which may cause sparks; (5) All oxygen tanks kept in the facility are secured in a stand or to a wall; (6) The equipment used to administer oxygen is in good working condition; (7) A portable unit for the administration of oxygen in the event of a power outage is present in the facility at all times when a resident who requires oxygen is present in the facility; and (8) The equipment used to administer oxygen is removed from the facility when it is no longer needed by the resident. Inspector Comments: Based on observation and interview, the facility failed to ensure oxygen tanks were secured. Findings include: On 01/05/23 at 2:05 PM, in Room #266, there was an unsecured oxygen tank located in the resident's closet in a plastic box lying on its side. On 01/05/23 at 2:05 PM, the Nurse confirmed the oxygen tank was unsecured and verbalized oxygen tanks were to be kept in a rack. Severity: 2 Scope: 1	0690	1. The one tank was removed from the resident's apartment and placed in a rack. The oxygen supplier was called and reminded of the storage requirements. 2. Ongoing training provided to all staff regarding storage requirements for oxygen. 3. Weekly walks of oxygen storage areas to include resident apartments utilizing oxygen. 4. All Wellness team members under the supervision of the Wellness Director. 5. Trainings were held on 2/22/23. Follow up meetings over the next month with monitoring to ensure understanding. 6. Staff sign in sheets.	03/15/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5232	A. BUILDING _____ B. WING _____	01/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADES OF THE SIERRA	275 NEIGHBORHOOD WAY, SPARKS, NEVADA ,89441

(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
0878 SS= D	Medication/OTCS, Supplements, Change Order - NAC 449.2742 - 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 has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician. 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 must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order; (2) Indicate on the container of the medication that a change has occurred; and (Previously Y 0879) (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 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, the 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 clinical record review and interview, the facility failed to ensure medications were on-site to administer as prescribed for 2 of 15 sampled residents (Resident #11 and #8). Findings include: Resident #11 Resident #11 was admitted to the facility on 10/26/22,	0878	1. Needed medications were re-ordered on the day of the survey. 2. Monthly cart audits are completed to review medication levels. Protocol for medication re-ordering developed and implemented. 3. Monthly cart audits are completed to review medications. 4. Medication Technicians under the direction of the Wellness Director. 5. Medication were on site by 1/6/23 and 1/9/23. 6. Photos of medications delivered	01/09/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5232	A. BUILDING _____ B. WING _____	01/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADES OF THE SIERRA	275 NEIGHBORHOOD WAY, SPARKS, NEVADA ,89441

(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
	with a diagnosis of dementia with behavioral disturbance. Resident #11's January 2023 Medication Administration Record (MAR) documented alprazolam 0.5 milligram (mg) tablet, give one tablet by mouth every two hours as needed (PRN) for agitation or shortness of breath. The PRN medication was not available on-site. On 01/05/23 at 2:45 PM, a Medication Technician confirmed the facility lacked Resident #11's PRN alprazolam. Resident #8 Resident #8 was admitted to the facility on 08/10/22, with a diagnosis of dysphagia following cerebral infarction and malignant neoplasm, unspecified. Resident #8's January 2023 Medication Administration Record (MAR) documented anti-diarrhea tablet 2 mg, give one tablet by mouth once daily PRN. The PRN medication was not available on site. On 01/05/23 at 3:00 PM, a Medication Technician confirmed the facility lacked Resident #11's PRN anti-diarrhea medication. The facility policy titled "Medication Assistance" last revised November 2012, documented all medications dispensed by the community were reordered in sufficient time to ensure residents did out run out of a medication. All medication associates were responsible for keeping track of the need for medication refills. A system of reporting medications needing refills was kept by each community and overseen by licensed personnel. Severity: 2 Scope: 1			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5232	A. BUILDING _____ B. WING _____	01/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADES OF THE SIERRA	275 NEIGHBORHOOD WAY, SPARKS, NEVADA ,89441

(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
0885 SS= D	Medication - Destruction - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 9. If the medication of a resident is discontinued, the expiration date of the medication of a resident has passed, or a resident who has been discharged from the facility does not claim the medication, an employee of a residential facility shall destroy the medication, by an acceptable method of destruction, in the presence of a witness and note the destruction of the medication in the record maintained pursuant to NAC 449.2744. Inspector Comments: Based on observation, clinical record review, interview and document review, the facility failed to ensure a discontinued medication was destroyed for 1 of 15 sampled residents (Resident #11). Findings include: Resident #11 Resident #11 was admitted to the facility on 10/26/22, with a diagnosis of dementia with behavioral disturbance. A physician's order dated 12/17/22, documented prednisolone one percent (1 %) suspension, administer one drop in both eyes four times daily for six days. Resident #11's medication bin contained a bottle of prednisolone 1% suspension eye drops with the instructions to instill the eye drops four times a day for five days. Filled on 12/19/22. On 01/05/23 at 2:46 PM a Medication Technician communicated the medication had been discontinued and should have been removed from Resident #11's medication bin and destroyed within seven days of completion of the medication. The facility policy titled "Medication Assistance" last revised November 2012, documented any discontinued medication should be disposed of according to state regulations and per pharmacy recommendations. Severity: 2 Scope: 1	0885	1. Medication cited in SOD was destroyed. 2. Monthly medication cart audits completed to ensure carts are in compliance with standards and regulations. 3. Monthly medication cart audits completed to ensure carts are in compliance with standards and regulations. 4. Medication technicians under the supervision of the Wellness Director. 5. Cart audits are completed monthly with the next one to be completed the first week of March. 6. Destruction record.	01/05/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5232	A. BUILDING _____ B. WING _____	01/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADES OF THE SIERRA	275 NEIGHBORHOOD WAY, SPARKS, NEVADA ,89441

(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
0895 SS= D	Administration of Medication Maintenance - NAC 449.2744 Administration of medication: Maintenance and contents of logs and records. (NRS 449.0302) 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall maintain: (b) A record of the medication administered to each resident. The record must include: (1) The type of medication administered; (2) The date and time that the medication was administered; (3) The date and time that a resident refuses, or otherwise misses, an administration of medication; and (4) Instructions for administering the medication to the resident that reflect each current order or prescription of the resident ' s physician. Inspector Comments: Based on observation, interview, clinical document review, and document review, the facility failed to ensure an as needed (PRN) medication had symptoms being treated documented on the Medication Administration Record (MAR) for 1 of 15 sampled residents (Resident #8). Resident #8 Resident #8 was admitted to the facility on 08/10/22, with a diagnosis of dysphagia following cerebral infarction and malignant neoplasm, unspecified. Resident #8's January 2023 Medication Administration Record (MAR) documented anti-diarrhea 2 milligram (mg) tablet, give one tablet by mouth once daily PRN. The PRN medication lacked the symptom to by treated. Resident #8's physician order dated 12/19/22, documented anti-diarrhea 2 mg tablet, every day PRN. The physician order lacked the symptom to be treated. On 01/05/23 at 3:00 PM, a Medication Technician confirmed the Resident #11's MAR lacked the symptom treated on the PRN anti-diarrhea medication. The facility policy titled "Medication Assistance" revised 04/2016, documented all PRN medications must have clear directions for use. When a PRN medication is given, the medication associate will document the reason for the medication and the resident's response to the medication. Severity: 2 Scope: 1	0895	1. An updated order was requested from the physician with the diagnosis requested. Medication was delivered with the diagnosis on the label. 2. Medications will be reviewed in monthly cart audit to ensure all information is included. 3. Monthly cart audit. 4. Medication Technicians under the supervision of the Wellness Director. 5. The medication arrived with the updated label on 1/9/23. 6. Photo of medication label.	01/09/2023
0920	Medication: Storage - NAC 449.2748	0920	1. Residents who self medicate all	03/15/202

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5232	A. BUILDING _____ B. WING _____	01/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADES OF THE SIERRA	275 NEIGHBORHOOD WAY, SPARKS, NEVADA ,89441

(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
SS= E	Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 1. Medication, including, without limitation, any over-the-counter 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 or herself without supervision may keep the resident ' s medication in his or her 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. Inspector Comments: Based on observation, document review, and interview, the facility failed to ensure resident medications were kept secured in the facility for 4 of 15 resident rooms with a resident self-administering medications (Room #248, #256, #258, and #370). Findings include: On 01/05/23, the following resident rooms contained unsecured medications: Room #248 - the resident was not in the room; however, the resident's medication was in an unlocked cabinet in the bathroom and the corridor door was unlocked. Room #256 - the resident was asleep; however, the resident's medication was not secured, and the corridor door was unlocked. Room #258 - the medication was not secured, and the resident verbalized the door was not always locked when not in the room. Room #370 - the resident verbalized the medications were not locked and the corridor door was not always locked. The facility policy titled, "Medication Self-Administration" revised November 2012 documented, "Medications will be kept in a secure location in the resident's room. On 01/05/23 at 1:24 PM through 2:00 PM, the Nurse confirmed medications were		received a verbal discussion regarding the need to lock up medication/apartment for the safety and well being of others. 2. A letter of understanding is being developed and sent out to all residents/ responsible parties regarding the rules for self medication. 3. Apartments of self medicating residents will be inspected monthly by Wellness team members identified by the Wellness Director. Residents out of compliance will be required to go on Medication Assistance programs. 4. Administrator will send out letter of understanding. Wellness team members will inspect under the direction of the Wellness Director. 5. The letter of understanding will go out by 3/15/23.	3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5232	A. BUILDING _____ B. WING _____	01/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADES OF THE SIERRA	275 NEIGHBORHOOD WAY, SPARKS, NEVADA ,89441

(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
	unsecured in Rooms #248, #256, #258, and #370. Severity: 2 Scope: 2			
0938 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 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: (g) An evaluation of the resident ' s ability to perform the activities of daily living and a brief description of any assistance he or she needs to perform those activities. The facility shall prepare such an evaluation: (1) Upon the admission of the resident; (2) Each time there is a change in the mental or physical condition of the resident that may significantly affect his or her ability to perform the activities of daily living; and (3) In any event, not less than once each year. Inspector Comments: Based on interview and document review, the facility failed to ensure an annual Activities of Daily Living (ADL) Assessment was completed for 7 of 15 sampled residents (Resident #12, #7, #13, #15, #5, #8, and #14). Findings include: Resident #12 Resident #12 was admitted to the facility on 12/28/21 with diagnosis including dementia and dysphagia. Resident #12's initial ADL Assessment was dated 12/28/21. The resident's clinical record lacked documented evidence an ADL assessment had been completed for 2022. Resident #7 Resident #7 was admitted to the facility on 07/17/19, with diagnoses including type II diabetes mellitus, hyperlipidemia and atherosclerotic heart disease. Resident #7's clinical record documented an ADL assessment last completed on 03/27/20. The resident's clinical record lacked documented evidence an ADL assessment had been completed for 2021 and 2022.	0938	1. A resident record review was completed for all residents cited in the inspection. ADL assessments were located for several of the residents and have been attached to this POC. 2. An audit tool has been put into place to ensure records are maintained under the guidance of regulation. Staff training has been completed to ensure that documents are not prematurely thinned from an active record. 3. Residents records will be reviewed semi-annually and upon change of condition to ensure that reviews are accurate and timely. 4. Wellness Director under the supervision of the Administrator. 5. All residents files will have a printed ADL assessment in their medical record by 3/15/23. 6. Completed ADL assessments	03/15/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5232	A. BUILDING _____ B. WING _____	01/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADES OF THE SIERRA	275 NEIGHBORHOOD WAY, SPARKS, NEVADA ,89441

(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
	Resident #13 Resident #13 was admitted to the facility on 12/31/20, with diagnoses including Alzheimer's disease, major depressive disorder and glaucoma. Resident #13's clinical record documented an ADL assessment last completed on 08/18/21. The resident's clinical record lacked documented evidence an annual ADL assessment had been completed for 2022. Resident #15 Resident #15 was admitted to the facility on 10/26/20, with diagnoses including anemia, osteoarthritis and repeated falls. Resident #15's clinical record documented an ADL assessment last completed on 10/26/20. The resident's clinical record lacked documented evidence an ADL assessment had been completed for 2021 and 2022. Resident #5 Resident #5 was admitted to the facility on 04/3/19, with diagnoses including dementia, diabetes mellitus, and hypertension. Resident #5's last annual ADL Assessment was dated 04/19/21. The resident's clinical record lacked documented evidence an ADL assessment had been completed for 2022. Resident #8 Resident #8 was admitted to the facility on 08/10/22, with a diagnosis of dysphagia following cerebral infarction and malignant neoplasm, unspecified. Resident #8's clinical record lacked an initial ADL Assessment. Resident #14 Resident #14 was admitted to the facility on 09/15/18, with a diagnosis of dementia. Resident #14's last annual ADL Assessment was dated 05/01/21. The resident's clinical record lacked documented evidence an ADL assessment had been completed for 2022. On 01/05/23 at 2:12 PM, the Wellness Director confirmed Resident #5 #7, #12,#13, #8, #14, and #15 lacked evidence of annual ADL assessments and verbalized ADL assessments were required to be completed upon admission and annually thereafter. In addition, all ADL assessments were required to be reviewed and signed by the Wellness Director to verify accuracy of the assessment. Severity: 2 Scope: 2			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5232	A. BUILDING _____ B. WING _____	01/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADES OF THE SIERRA	275 NEIGHBORHOOD WAY, SPARKS, NEVADA ,89441

(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
0950 SS= D	Hospice Care Responsibilities of Staff - NAC 449.275 Residential facility which provides residents with hospice care: Responsibilities of staff; retention of resident with special medical needs. (NRS 449.0302) 1. A residential facility that provides services to a resident who elects to receive hospice care shall obtain a copy of the plan of care required pursuant to NAC 449.0186 for that resident. Inspector Comments: Based on interview and document review, the facility failed to ensure a hospice Plan of Care was was obtained and retained by the facility for a resident receiving hospice care for 1 of 15 sampled residents (Resident #12). Findings include: Resident #12 Resident #12 was admitted to the facility on 12/28/21 with diagnosis including dementia and dysphagia. On 01/05/23 at 4:02 PM, the Interim Executive Director (ED) confirmed Resident #12 was receiving hospice care from an outside agency and the facility did not have the resident's Plan of Care upon request from the State Survey Agency. The ED explained it would need to be faxed to the facility. Severity: 2 Scope: 1	0950	1. The hospice provider was informed of their need to have records on site. Plan of care for the resident cited was obtained and it is on file. 2. A record review was completed for all resident's receiving hospice services. A Hospice Plan of Care is on site for each of these residents. 3. All residents on hospice will be reviewed routinely to ensure documents are compliant. 4. The Wellness Director will designate a wellness team member to review records. 5. The Plan of care was obtained 2/23/23. 6. Plan of care attached.	02/23/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5232	A. BUILDING _____ B. WING _____	01/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADES OF THE SIERRA	275 NEIGHBORHOOD WAY, SPARKS, NEVADA ,89441

(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
0994 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 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 shall ensure that: (e) Knives, matches, firearms, tools and other items that could constitute a danger to the residents of the facility are inaccessible to the residents. Inspector Comments: Based on observation and interview the Administrator failed to ensure resident safety by removing dangerous items from a common area in the memory care unit. Findings include: On 01/05/23 at 11:34 AM, a common area in the memory care unit had a heat-producing electric fireplace accessible to all residents in the unit. On 01/05/23 at 11:34 AM, the Corporate Executive Director confirmed the fireplace generated heat and verbalized not knowing the fireplace should not be accessible to residents in a memory care unit. Severity: 2 Scope: 3	0994	1. On the day of the survey, the electric, decorative fireplace was removed from the memory care. The heating function of the unit was disabled. 2. The heating function of the unit was disabled and it unable to be used for anything but decoration. 3. The memory care unit will continue to be included in daily safety walks. 4. The fireplace was removed on day of survey and was not returned to memory care until the heating function was disabled. 5. 1/5/23	01/05/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5232	A. BUILDING _____ B. WING _____	01/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADES OF THE SIERRA	275 NEIGHBORHOOD WAY, SPARKS, NEVADA ,89441

(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
0999 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 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 shall ensure that: (g) All toxic substances are not accessible to the residents of the facility. Inspector Comments: Based on observation and interview, the facility failed to ensure toxic substances were inaccessible to residents housed in the memory care unit. Findings include: On 01/05/23 at 10:47 AM, a container of Avon Glaze Wear shine lip gloss was unsecured in room #182A. On 01/05/23 at 10:56 AM, a 16-ounce container of Trader Joe's moisturizing cream, a bar of Essentials by Clearly Glycerin Unscented soap with a Safety Data Sheet which documented the soap was hazardous, and a bottle of Refresh tears were unsecured in room #197B. On 01/05/23 at 11:12 AM, a 16-ounce bottle of Lubriderm Intense Skin Repair lotion was unsecured in room #172A. On 01/05/23 at 11:17 AM, a 0.85-ounce tube of Crest with Scope toothpaste was unsecured in the bathroom of room #170B. On 01/05/23 at 11:28 AM, a bottle of She Pink Pepper with Amber Room Spray, and two bottles of Sparoom Cotton Linen Spray were unsecured in the bathroom of room #171B. The facility policy titled, "Environmental Safety," revised November 2012, documented, "Supplies for resident activities should be non-toxic." On 01/05/23 at 10:47 AM through 11:28 AM, the Corporate Executive Director confirmed the presence of unsecured substances in rooms #181A, #197B, #177A, #172A, #170B, and #171B. Severity: 2 Scope: 3	0999	1. Resident apartments have been completely reviewed to ensure compliance will all potentially dangerous items. 2. Training provided to all team members reviewing items that could be potentially dangerous and the need to secure the items. 3. Ongoing spot checks throughout the unit to check for potentially dangerous items. A letter of understanding will go out to all family members to assist in the compliance of securing potentially dangerous items. 4. Wellness team members identified by the Wellness Director. 5. Wellness staff meetings were held on 2/22/23 with ongoing trainings anticipated 3/15/23 with all staff. Letter to families to go out by 3/15/23. 6. Staff meeting sign in sheets for the 2/22/23 staff meetings.	03/15/2023
1540 SS= F	Cultural Competency Training Inspector Comments: Based on personnel record review and interview, the facility failed to ensure cultural competency training was completed timely for 12 of 12 sampled employees required to obtain cultural competency training (Employees #1, #3, #4, #6, #7, #8, #9, #10, #13, #14,	1540	1. All associate files were reviewed. Cultural Competency has been completed for all associates or the associates were removed from the schedule until compliance was met. 2. All associates will be scheduled to complete the Cultural Competency within the first 30 days of hire. 3. Audits of the training files will be	03/01/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5232	A. BUILDING _____ B. WING _____	01/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADES OF THE SIERRA	275 NEIGHBORHOOD WAY, SPARKS, NEVADA ,89441

(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
	#17, and #20). Findings include: Employee #1 Employee #1 was hired as Nurse with a start date of 04/11/17. The personnel record for Employee #1 had a cultural competency training certificate dated 12/16/22. Employee #2 Employee #2 was hired as Life Enrichment Associate with a start date of 10/10/22. The personnel record for Employee #2 had a cultural competency training certificate dated 12/4/22. Employee #3 Employee #3 was hired as Nurse with a start date of 10/11/17. The personnel record for Employee #3 had a cultural competency training certificate dated 11/30/22. Employee #4 Employee #4 was hired as Life Enrichment Associate with a start date of 07/27/17. The personnel record for Employee #4 had a cultural competency training certificate dated 12/02/22. Employee #6 Employee #6 was hired as Administrator with a start date of 03/30/08. The personnel record for Employee #6 had a cultural competency training certificate dated 11/21/22. Employee #7 Employee #7 was hired as Life Enrichment Associate with a start date of 08/06/21. The personnel record for Employee #7 had a cultural competency training certificate dated 11/30/22. Employee #8 Employee #8 was hired as Medication Technician with a start date of 05/05/22. The personnel record for Employee #8 had a cultural competency training certificate dated 12/31/22. Employee #9 Employee #9 was hired as Life Enrichment Director with a start date of 08/19/20. The personnel record for Employee #9 had a cultural competency training certificate dated 12/01/22. Employee #10 Employee #10 was hired as Medication Technician with a start date of 11/15/22. The personnel record for Employee #4 had a cultural competency training certificate dated 12/01/22. Employee #13 Employee #13 was hired as Care Associate with a start date of 05/31/22. The personnel record for Employee #13 had a cultural competency training certificate dated 12/06/22. Employee #14 Employee #14 was hired as Medication Technician with a start date of 11/18/22. The personnel record for Employee #13 had a cultural competency training certificate dated 12/01/22.		completed monthly by the Business Office Manager under the supervision of the Executive Director. 4. Business Office Manager under the supervision of the Executive Director 5. This process will be in place by March 1, 2023. 6. Audit tracker attached.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5232	A. BUILDING _____ B. WING _____	01/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADES OF THE SIERRA	275 NEIGHBORHOOD WAY, SPARKS, NEVADA ,89441

(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
	Employee #17 Employee #17 was hired as Medication Technician with a start date of 08/15/22. The personnel record for Employee #13 had a cultural competency training certificate dated 12/02/22. Employee #20 Employee #20 was hired as Medication Technician with a start date of 10/21/18. The personnel record for Employee #13 had a cultural competency training certificate dated 11/30/22. On 01/05/23 at 2:25 PM, the Corporate Executive Director confirmed the cultural competency training for all employees was completed late. Cultural competency training was due to be completed no later than 07/01/22. Severity: 2 Scope: 3			
1700 SS= D	Annual Assessment of History of Each Resident Inspector Comments: Based on interview and document review, the facility failed to ensure an annual Physician Determination form was obtained to confirm the resident was in proper placement for 3 of 15 sampled residents (Resident #12, #5 and #14). Findings include: Resident #12 Resident #12 was admitted to the facility on 12/28/21, with diagnoses including dementia and dysphagia. Resident #12's initial Physician Determination was completed on 12/10/21. Resident #5 Resident #5 was admitted to the facility on 04/3/19, with diagnoses including dementia, diabetes mellitus, and hypertension. Resident #5's initial Physician Determination was completed on 03/28/19. Resident #14 Resident #14 was admitted to the facility on 09/15/18, with a diagnosis of dementia. Resident #14's inital Physician Determinatiomn was completed on 03/25/20. On 01/05/23 at 2:13 PM, the Wellness Director confirmed Resident #12, #5, and #14 did not have an annual Physician Determination completed to confirm the residents were in proper placement at the facility. Severity: 2 Scope: 1	1700	1. A physician determination request was made to the physician's of the resident's cited in the SOD. One of the 3 resident's was asked to move to memory care prior to receipt of the SOD and the family chose to discharge to a group home. 2. All resident records were reviewed to locate resident's with a dementia diagnosis to ensure an annual determination was completed by physicians. 3. Resident records will be completed semi-annually and upon change of condition. 4. Wellness team members as designated by the Wellness Director. 5. Physician discussions occurred by 2/17/23. 6. Fax notifications	03/01/2023