

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

PRINTED: 6/15/2026
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/19/2022
NAME OF PROVIDER OR SUPPLIER CASCADES OF THE SIERRA			STREET ADDRESS, CITY, STATE, ZIP CODE 275 NEIGHBORHOOD WAY, SPARKS, NEVADA ,89441	
(X4) ID PREFIX TAG 0000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG 0000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation conducted at your facility on 10/19/22, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The census at the time of the survey was 70. The sample size was five. The facility received a grade of A. There was one complaint investigated. Complaint# NV00066936 with the following allegations could not be substantiated: The allegation of a resident's missing wedding ring could not be substantiated for being stolen due to a lack of evidence. The investigation into the allegations included: Observations of residents and staff in common areas, lobby, and outdoor common areas. Interviews were conducted with the Administrator, a Med Tech, and five residents in the facility. Reviewed seven resident records, including the resident of concern, nursing, medication technician, and care associate staffing schedules dated 08/19/22 through 08/20/22, and the residency agreement signed by the resident of concerns representative. 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. No regulatory deficiencies were identified. No further action is necessary. Please retain a copy of this Statement of Deficiencies for your records.			

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

Title:

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.