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 _____	**07/30/2024**

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

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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 05/16/2024 and complaint investigation on 07/30/2024, 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 91. 22 resident records and 25 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. There were three complaints investigated. Complaint #NV00071675 with the following allegation was substantiated for resident to resident sexual abuse (See Tag Y0590). Allegation #1: A resident was found molesting another resident in memory care. The following allegations could not be substantiated due to lack of evidence: Allegation #2: A resident with a behavior of "disappearing" in Assisted Living was sent to Memory Care so staff would not have to look for the resident and transfer paperwork to Memory Care was not filled out and family was not notified of the resident transfer. Allegation	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: CHRIS K GARDNER Title: Executive Director Date: 10/05/2024

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	#3: The facility was short staffed. Complaint# NV00071679 with the following allegations could not be substantiated due to lack of evidence: Allegation #1: the facility had no nurses on staff in the building for 24 hours. Allegation #2: neglect towards residents had increased over the last few weeks. Allegation #3: there was lack of communication with resident families related to the residents care. The investigation into the allegations included: Observations of residents and staff in common areas and lobby. Interviews were conducted with the Administrator/Executive Director, a Med Tech, and a Care Associate. Reviewed Manager duty schedule, Administrator license and training and facility schedules. Complaint #NV00071653 with the following allegation was substantiated (See tag Y0590). Allegation #1: A resident escaped memory care and was out in the outdoor courtyard all night resulting in hopitalization for dehydration. The following allegations could not be substantiated due to a lack of evidence. Allegation #2: there was lack of communication between the resident's family and the facility. Allegation #3: admission paperwork was not signed for resident to reside in memory care. Investigation into the allegations included: Observations of residents and staff in common areas and lobby, the facility grounds, exits including door handles, and resident - staff interactions. Interviews were conducted with a Care Associate, a Medication Technician, the Wellness Director, and the Assistant Executive Director. Record review included face sheets with diagnoses, communication documentation and admission documentation. 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			

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	or local laws. The following regulatory deficiencies were identified:			
0590 SS= G	Rights of Residents; Procedure for Filing - NAC 449.268 Rights of residents; procedure for filing grievance, complaint or report of incident; investigation and response. (NRS 449.0302) 1. The administrator of a residential facility shall ensure that: (a) The residents are not abused, neglected or exploited by a member of the staff of the facility, another resident of the facility or any person who is visiting the facility; Inspector Comments: Based on record review and interview, the administrator failed to ensure a resident's care was not neglected (Resident #21) and a resident was kept safe from sexual abuse by another resident (Resident #15) for 2 of 16 residents residing in the memory care unit. Findings include: Resident #21 Resident #21, the resident of concern, was admitted to the facility on 07/02/2024, with diagnoses including vascular dementia, unspecified, repeated falls and age-related physical debility. An Incident/Accident Report dated 07/07/2024 at approximately 6:20 AM, documented Resident #21 was found by a Medication Technician outside laying on the patio of the courtyard half naked. On 07/30/2024 at 11:28 AM, a Medication Technician explained there were two doors leading to the courtyard and the Medication Technicians were the only ones who had a key for those doors. The doors were to be unlocked at 6:00 AM and locked at 8:00 PM, pending weather advisories. When the Medication Technicians unlocked or locked the patio doors, they were to conduct a walk through to ensure cleanliness and ensure no residents were outside. The patio doors locked from the inside, however always remained unlocked from the outside, in the event a resident was to still be outside they were sure to be able to get back in. The Medication Technician verbalized care staff was to complete two-hour checks on the	0590	1. Resident#21 was found and sent to the hospital for evaluation and treatment. His family and physician were notified of the incident. Resident #22 was reported to the Washoe County Sheriff's Office who conducted an investigation into the incident. 2. **Regarding incident with Resident #21:** As of 10/4/24, a medication associate task has been added to the QuickMar medication administration system stating: Memory care associates will conduct a thorough canvas of the memory care courtyard daily between 7:00 p.m. and 8:00 p.m. to ensure all residents are accounted for and no resident is left outside in the courtyard before securing the doors. Once the canvas is complete, courtyard doors will be securely locked. By 10/30/2024, The Executive Director (ED) and/or a designee will provide targeted education and training to all memory care associates on the importance of securing the memory care courtyard doors. Training content to include: procedures for properly securing the courtyard doors, listening for door alarms when doors opened and closed (and what to do if alarms are not sounding) the necessity of ensuring all residents are inside and accounted for before locking doors, emphasis on the time-sensitive nature of this task (between 7:00p.m. and 8:00 p.m. daily) and where to document completion of task. ED and/or designee to visually monitor task daily x 1 week, weekly x 4 weeks, monthly thereafter and as needed until compliance is met. **Regarding incident with Resident #22:** By 10/30/24, the Executive Director (ED) and/or a designee will be	07/06/2024

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	residents and ensure comfortable, still breathing, and complete brief changes. The Medication Technician verbalized being notified at the start of the shift on 07/07/2024 by the night shift Care Associate, Resident #21 had not been in their room since 3:00 AM and was missing from the locked memory care unit. The Medication Technician explained beginning morning tasks, including unlocking the patio doors. When the Medication Technician unlocked patio doors and conducted a walk-through the Medication Technician located Resident #21 lying outside with shirt off and using the shirt as a blanket. Immediately contacted 911, Wellness Director, and Executive Director. On 07/30/2024 at 1:31 PM, a Care Associate explained residents were able to go outside in the morning until temperatures became too hot and the Medication Technicians would lock the doors for resident safety. The Care Associate verbalized residents were not typically allowed outside unsupervised, however if a resident did go outside residents were never locked out as the doors were always unlocked from the outside. The Care Associate verbalized rounding on resident every hour and a half to two hours. If the Care Associate was ever unable to locate a resident, they would need to notify the Medication Technician and then contact Wellness Director and/or the Executive Director. The Care Associate verbalized coming on shift the morning of 07/07/2024, when the incident with Resident #21 occurred. The Care Associate explained both patio doors were locked when the Medication Technician went out there shortly after 6:00 AM. The only way the resident got out there was if Resident #21 was outside prior to the night shift Medication Technician locking the doors in the evening of 07/06/2024. The Care Associate explained the resident being left outside all night was considered neglect. On 07/30/2024 at 3:47 PM, the Wellness Director and Assistant Executive Director		responsible for ensuring all employees receive comprehensive training on abuse and neglect. Training content to include how to recognize signs of abuse and neglect (physical, emotional, sexual, etc.), procedures for reporting suspected abuse, neglect, or inappropriate behaviors and the importance of immediate action and accurate reporting. This training will specifically cover behaviors that both residents and staff may deem inappropriate, emphasizing the importance of further investigation and intervention. Ongoing compliance to be monitored by ED and/or designee via incident report review and audit of any new allegations of sexual abuse via QA meeting weekly x 4 weeks and monthly thereafter. 3. **Regarding incident with Resident #21:** ED and/or designee to evaluate effectiveness of corrections through monthly review of Quickmar task audits. Results of the audits will be discussed during the monthly QA meetings. The QA Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be ongoing. **Regarding incident with Resident #22:** All incident reports of alleged neglect/abuse to be reviewed at monthly QA meetings with any additional investigation or training on event(s) determined by QA Committee. The QA Committee will retain auditing records. 4. ExecutiveDirector will ensure the plan of correction is properly implemented. 5. Resident#22 moved out of the community on 7/6/24. Resident #21 moved out of community to be closer to family on 9/3/24.	

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	explained staff were expected to round on the residents in the memory care unit at least every two hours. Staff was notified of new residents by 24 hours report, shift change report and Medication Technician was able to pull notes. The Wellness Director verbalized neglect would be not carrying out shift duties, and care for residents, such as nutrition, fluids and keeping the resident in a safe environment. The Wellness Director and Assistant Executive Director verbalized the investigation conducted at the facility regarding Resident #21 on 07/07/2024, included interviewing the staff, notifying the physician and Resident #21's family. The Wellness Director explained on the evening of 07/06/2024, the swing shift staff had assisted Resident #21 to bed around 9:45 PM. The night shift staff informed upper management having been busy dealing with issues with another resident and did not identify Resident #21 was missing from their room until approximately 3:00 AM. The night shift Care Associate was unsure if Resident #21 was moved into the facility or not. The Wellness Director and Assistant Executive Director both verbalized staff was able to contact upper management at any time and would if another shift had not taken the trash out. The Wellness Director and Assistant Executive Director confirmed this incident would be neglect for a resident to not be rounded on for minimum for five hours, and management was not notified until resident was located and sent out to the hospital. The facility policy titled "Missing Resident Protocol," issued 06/2012, documented all associates would be notified and a complete search of the building would occur immediately upon notice a resident was missing. If searching the building was unsuccessful in finding the resident, the associate would search outside the community. Complaint #NV00071653 Resident #22 Resident #22 was admitted to the facility on 12/02/2023, with diagnoses including peripheral			

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	neuropathy, renal insufficiency, and restless leg syndrome. A Physician Order Form dated 01/29/2024, documented communication from the Assisted Living unit to the physician: Resident #22 requested a hug from a caregiver and then attempted to grab the caregiver's breast. While the caregiver was taking care of Resident #22's spouse, Resident #22 was in the bed next to the spouse playing with themselves. Please advise. A Physician Order Form dated 04/08/2024, documented communication from the Assisted Living unit to the physician: Resident #22 was having inappropriate sexual behaviors toward staff. Resident has been spoken to about this behavior. A Physician Order Form dated 05/04/2024, documented communication from the Assisted Living unit to the physician: Resident #22 continues to have behaviors of inappropriately touching staff. A Physician Order Form dated 06/03/2024, documented communication from the Assisted Living unit to the physician: caregiver was helping Resident #22 put on pants when the resident pushed the caregivers head in their lap and proceeded to tell the caregiver the things the resident wanted to do to the caregiver. A Behavior Incident Report from a Caregiver dated 07/05/2024 at 5:15 AM, documented Resident #22 was not located in their bed. A room search was held, and Resident #22 was found naked in Resident #15's bed. Resident #15 did not have a brief on. Resident #22 was naked and touching and rubbing Resident #15. A Behavior Incident Report from a Medication Technician (MT) dated 07/05/2024 at 5:15 AM, documented Resident #22 was found naked in Resident #15's bed. Resident #15 did not have a brief on. Resident #22 was naked and touching and rubbing Resident #15. The report documented Resident #22 had a history of doing similar things. A Medication Associate Alert Charting note dated 07/05/2024 at 7:02 AM, documented Resident #22 was found in Resident #15's bed, naked.			

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	Resident #15 did not have on a brief. The Caregiver reported the Caregiver reported they observed Resident #22 touching and rubbing Resident #15. Resident #22 told the Caregiver not to say anything and became combative when the caregiver asked them to go to their room. At around 6:00 AM, Resident #22 was found in another resident's room. A Health Status Note from the Wellness Director dated 07/05/2024, documented the Wellness Director was notified via text message and phone call Resident #22 was found in Resident #15's room, unclothed in Resident #15's bed. Resident #15's brief was removed from her body. Resident #22 reported being in Resident #15's room, being lonely and asking Resident #15 to cuddle after waking them up from sleep. Resident #15 Resident #15 was admitted to the facility on 12/27/2022, with diagnoses including severe Alzheimer's disease, dementia with behavioral disturbance, and generalized anxiety. A Health Status Note for Resident #15 dated 07/05/2024, documented the Wellness Director was notified by a MT and a Caregiver there was an incident in Memory Care with Resident #15 and Resident #22. When completing rounds in the morning, a caregiver entered Resident #15's apartment to find Resident #22 without clothing in Resident #15's bed. Resident #15 was without a brief. On 07/30/2024 at 2:30 PM, MT1 verbalized Resident #22 had a behavior of making inappropriate comments about MT1's body and would make sexual comments about staff and residents to staff and residents. The MT1 recalled they were informed Resident #22 had been removed from memory care due to being found in another resident's bed with no clothing. On 07/30/2024 at 3:19 PM, the Executive Director (ED) verbalized Resident #22 was moved to memory care to protect the resident from themselves and moved out of memory care to protect the memory care residents from Resident #22. Resident #22			

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	was initially admitted to the facility on the assisted living side, however due to multiple elopement attempts, the resident was moved into memory care. The ED explained Resident #22 was found naked in Resident #15's bed. Resident #15 was naked from the waist down. On 07/30/2024 at 3:27 PM, the Assistant Executive Director (AED) verbalized staff did not like the way Resident #22 interacted sexually with their spouse. The staff felt Resident#22 behaved in sexually inappropriate ways with their spouse, however the staff did not report inappropriate behavior with other residents. The staff did report Resident #22 was inappropriate with female staff members, such as grabbing a caregiver's breast and making inappropriate comments. On 07/30/2024 at 3:34 PM, the Wellness Director verbalized Resident #22 was inappropriate with female staff members, however the staff did not report inappropriate behavior with other residents, other than Resident #22's spouse. Staff reported they would enter the resident's room to find the resident fondling or having sex with their spouse. The spouse never said no, but there was concerns regarding their level of consent. The family was aware and ok with the behavior. The Wellness Director explained staff should report and document any instances of inappropriate behaviors such as physical touching or sexual comments. On 07/30/2024 at 4:12 PM, the AED verbalized they would consider Resident #15 to have been a victim of resident to resident sexual abuse. On 07/30/2024 at 4:30 PM, the Memory Care Coordinator (MCC) verbalized Resident #22 had a higher mental capacity than most in the memory care unit. Resident #15 had severe dementia and confusion and did not have the mental capacity to consent. The MCC explained the MCC had concerns about Resident#22 in the memory care due to the behaviors displayed on the assisted living side of the facility. The facility policy titled "Abuse and			

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	Neglect," revised 05/2018, documented neglect means the failure of a person who had assumed legal responsibility or a contractual obligation for caring for an older person or a vulnerable person for his or her care to provide food, shelter, clothing, or services which were necessary to maintain the physical or mental health of the older person or vulnerable person. Severity: 3 Scope: 1			
0859 SS= D	Medical Care of Resident After Illness - NAC 449.274 and R043-22 Medical care of resident after illness, injury or accident; periodic physical examination of resident; rejection of medical care by resident; written records. (NRS 449.0302) 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by a qualified provider of health care in accordance with NRS 449.1845. The resident must be cared for pursuant to any instructions provided by the qualified provider of health care. Inspector Comments: Based on clinical record review and interview, the facility failed to ensure an annual general physical examination was completed timely for 1 of 20 sampled residents (Resident #8). Findings include: Resident #8 Resident #8 was admitted to the facility on 12/09/2022, with diagnoses including mild cognitive impairment, hyperlipidemia, and other arthritis. Resident #8's clinical record documented an initial physical exam completed on 10/25/2022, and an annual completed on 12/12/2023. The 2023 physical exam was completed 49 days late. On 05/16/2024 at 3:58 PM, the Wellness Director confirmed Resident #8's annual physical for 2023 was completed late. Severity: 2 Scope: 1	0859	1. Resident#8 received a general physical examination from her primary physician on7/31/24. 2. No other residents were identified as being deficient. 3. Wellness Director will ensure that due dates for annual physical examination are accurate in the electronic medical record and notifications are made timely to ensure sufficient time to schedule and hold the examination. 4. Tracking log for physician annual physical will be monitored at least monthly by Wellness Director who will ensure compliance. 5. Physical exam was completed on 7/31/24.	07/31/2024
0920 SS= D	Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge,	0920	1. On the day of annual survey,	08/18/2024

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	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 2 of 25 resident rooms with a resident self-administering medications (Room #362B, and #248). Findings include: On 01/05/23, the following resident room contained unsecured medications: Room #248 - the medication was in a kitchen cabinet secured by a ratcheting child lock, and the resident verbalized the door was not always locked when not in the room. On 05/16/2024 at 2:28 PM, the Maintenance Director verbalized a lock would need to be installed on the cabinet door to ensure the medication was adequately secured in the room. Resident #17 Resident #17 was admitted on 07/10/2023, with diagnoses including cerebral infarction, essential hypertension, and hypothyrodism. Resident #17 shared Room 362B with a resident who administered their own medications, unsampled Resident #23. On 05/16/24 in		medications were secured in locked drawers in resident rooms. 2. No other residents were identified as having unsecured medications. 3. Both residents were counseled to keep medications secured in their apartments. 4. A Med Tech is assigned for each shift to monitor safe medication storage in each resident's room and documents those checks are completed in the electronic medication administration record. 5. Med Techs began monitoring during each shift on 8/18/24.	

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	the afternoon, Resident #17 and Resident #23 were in Room 362B. On 05/16/2024 at 3:00 PM, Resident #23 verbalized some of their medications were secured in a locked drawer, but other medications were unsecured. Resident #23 explained one medication was in the kitchen cupboard because they took it often, and the other medication, Lunesta, had been behind the computer for about five days because they were waiting for refills and wanted to get the information correct when they entered the medication details in the computer. On 05/16/2024 at 3:01 PM, a medication bottle was in the kitchen cupboard. The bottle was labeled Pentoxifylline 400 milligrams (mg), take three times a day with meals. Six tablets were in the bottle. On 05/16/2024 at 3:03 PM, a medication bottle was behind the computer in the residents' office room. The bottle was labeled Eszopiclone 2 mg, take one tablet at bedtime; generic for Lunesta. Six tablets were in the bottle. On 05/16/2024 at 3:17 PM, the Wellness Director witnessed the unsecured medications in Room 362B and told Resident #23 all medications needed to be locked up. On 05/16/2024 at 3:18 PM, Resident #23 pulled a yellow pill from their pocket and identified the pill as Pentoxifylline. The Wellness Director told them this pill also needed to be secured. On 05/16/24 at 3:13 PM, the Wellness Director said the facility policy stated medications should not be in resident rooms. Severity: 2 Scope: 1			

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		A. BUILDING _____ B. WING _____	**07/30/2024**

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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 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 document review, clinical record review and interview, the facility failed to ensure 1 of 20 sampled residents met the requirements concerning tuberculosis (TB) testing in accordance with Nevada Administrative Code (NAC) 441A (Resident #11). Findings include: Resident #11 Resident #11 was admitted to the facility on 12/29/23, with diagnoses including dementia, and urinary incontinence. Resident #11's clinical record contained a one TB test given on 12/21/2023 and read negative on 12/23/2023. The clinical record lacked a second step TB test. On 05/16/2024 at 3:20 PM, the Wellness Director verbalized a two step TB was required to be completed upon admission to the facility. The Wellness confirmed Resident #11 did not have a second step TB test completed. Severity: 2 Scope: 1	0936	1. Resident received a negative 2-step TB test on 5/18/24. 2. No other residents were found to be deficient. 3. Wellness Director will monitor all new resident move ins to ensure they have complete and negative TB tests prior to move in and annually thereafter. 4. Wellness Team maintains a tracking log, which they review at least monthly, to remind when TB tests are due for each resident. 5. Negative test was administered on 5/18/24.	05/18/2024
1300 SS= C	Discrimination prohibited - NRS 449.101 Discrimination prohibited; development of antidiscrimination policy; posting of nondiscrimination statement and certain other information; construction of section. [Effective January 1, 2020.] 1. A medical facility, facility for the dependent or facility which is otherwise required by regulations	1300	1. Theno-discrimination policy was drafted and posted prominently in the community and to the website on 5/18/24. 2. No other residents were effected by this deficiency.	05/18/2024

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	adopted by the Board pursuant to NRS 449.0303 to be licensed and any employee or independent contractor of such a facility shall not discriminate in the admission of, or the provision of services to, a patient or resident based wholly or partially on the actual or perceived race, color, religion, national origin, ancestry, age, gender, physical or mental disability, sexual orientation, gender identity or expression or human immunodeficiency virus status of the patient or resident or any person with whom the patient or resident associates. 2. A medical facility, facility for the dependent or facility which is otherwise required by regulations adopted by the Board pursuant to NRS 449.0303 to be licensed shall: (a) Develop and carry out policies to prevent the specific types of prohibited discrimination described in the regulations adopted by the Board pursuant to NRS 449.0302 and meet any other requirements prescribed by regulations of the Board; and (b) Post prominently in the facility and include on any Internet website used to market the facility the following statement: [Name of facility] does not discriminate and does not permit discrimination, including, without limitation, bullying, abuse or harassment, on the basis of actual or perceived race, color, religion, national origin, ancestry, age, gender, physical or mental disability, sexual orientation, gender identity or expression or HIV status, or based on association with another person on account of that person's actual or perceived race, color, religion, national origin, ancestry, age, gender, physical or mental disability, sexual orientation, gender identity or expression or HIV status. 3. In addition to the statement prescribed by subsection 2, a facility for skilled nursing, facility for intermediate care or residential facility for groups shall post prominently in the facility and include on any Internet website used to market the facility: (a) Notice that a patient or resident who has experienced prohibited discrimination may		3. No-discrimination policy posting is permanent in community and on website. 4. No-discrimination policy will be reviewed annually to ensure proper placement. 5. Policy was posted in the community and on the website on 5/18/24.	

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	file a complaint with the Division; and (b) The contact information for the Division. 4. The provisions of this section shall not be construed to: (a) Require a medical facility, facility for the dependent or facility which is otherwise required by regulations adopted by the Board pursuant to NRS 449.0303 to be licensed or an employee or independent contractor thereof to take or refrain from taking any action in violation of reasonable medical standards; or (b) Prohibit a medical facility, facility for the dependent or facility which is otherwise required by regulations adopted by the Board pursuant to NRS 449.0303 to be licensed from adopting a policy that is applied uniformly and in a nondiscriminatory manner, including, without limitation, such a policy that bans or restricts sexual relations. Inspector Comments: Based on observation, document review, and interview, the facility failed to have a policy to document, investigate, and resolve a report of discrimination, or to ensure a non-discrimination statement was posted. Findings include: On 05/16/2024, observation throughout the facility revealed the required non-discrimination statement was not posted at the facility entrance or in the dining room. On 05/16/2024 at 3:30 PM, a review of the resident move-in binder revealed the lack of the required non-discrimination statement and the information for filing a non-discrimination complaint. On 05/16/2024, at 3:45 PM, the Administrator verbalized the facility lacked a written policy for how a non-discrimination complaint would be documented, investigated, and resolved. The facility lacked a log listing all complaints, actions taken, and resolutions. On 05/16/2024 at 3:45 PM, the Administrator confirmed the facility had not established policies regarding non-discrimination complaints, investigations, and resolutions. Scope: 3 Severity: 1			
1400	Duties of licensed facility to protect - NRS	1400		10/15/202

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

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SS= C	449.102 Duties of licensed facility to protect privacy of patient or resident. [Effective January 1, 2020.] A medical facility, facility for the dependent or facility which is otherwise required by regulations adopted by the Board pursuant to NRS 449.0303 to be licensed shall: 1. Maintain the confidentiality of personally identifiable information concerning the sexual orientation of a patient or resident, whether the patient or resident is transgender or has undergone a gender transition and the human immunodeficiency virus status of the patient or resident and take reasonable actions to prevent the unauthorized disclosure of such information; 2. Prohibit employees or independent contractors of the facility who are not performing a physical examination or directly providing care to a patient or resident from being present during any portion of the physical examination or care, as applicable, during which the patient or resident is fully or partially unclothed without the express permission of the patient or resident or the authorized representative of the patient or resident; 3. Use visual barriers, including, without limitation, doors, curtains and screens, to provide privacy for patients or residents who are fully or partially unclothed; and 4. Allow a patient or resident to refuse to be examined, observed or treated by an employee or independent contractor of the facility for a purpose that is primarily educational rather than therapeutic Inspector Comments: Based on interview, the facility failed to: (1) maintain the confidentiality of personally identifiable information concern sexual orientation, gender identity, and human immunodeficiency virus (HIV) status of a resident, (2) prohibiting employees or independent contractors who are not performing a physical exam or directory providing care to a resident from being present during any portion of examination		1. The privacy policy will be drafted and included in the policy and procedure manual for the community. 2. No other residents were effected by this deficiency. 3. Privacy policy will become a permanent part of the policy manual for the community. 4. Privacy policy will be reviewed annually to ensure continued compliance with current regulations. 5. Policy will be completed and implemented by 10/15/2024.	4

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	or care, (3) use of physical barriers to provide privacy for residents who are fully or partially unclothed, and (4) allowing a resident to refuse to be examined, observed, or treated by an employee or contractor of the facility for a purpose that is primarily educational rather than therapeutic, in compliance with Nevada Revised Statute (NRS) 449.102. Findings include: On 05/16/2024, at 3:45 PM, when a privacy policy was requested, the Administrator verbalized the facility lacked a written policy for maintaining the privacy of a resident in compliance with NRS 449.102. Severity: 1 Scope: 3			