Division of Public and Behavioral Health

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 _____	04/09/2026

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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RFG 0001-Deficiencies	The Statement of Deficiencies was generated as a result of a state licensure survey conducted in your facility, in accordance with Nevada administrative code, chapter 449, and Nevada revised statutes chapter 449- Residential Facility for Groups (RFG), medical facilities and other related entities. The findings and conclusions of any investigation by the Division of Health Care Purchasing and Compliance shall not be construed as prohibiting any criminal civil investigation, actions or other claims for reliefs that may be available to any party under applicable federal, state or local law. Based on an inspection conducted, the items marked below identify the violation in operation of the RFG which must be corrected by the revisit/compliance date specified in writing by the health authority. Failure to comply with this notice and immediately correct the identified deficiencies may result in the suspension or termination of your provider agreement, funding, or future authorization as a provider authorized by the State	RFG 0001-Deficiencies		

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	of Nevada pursuant to NAC 433.384, and other applicable local and state laws. Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation, and mandatory re-grading survey completed at your facility on 04/09/2026. The facility is licensed for 120 Residential Facility for Group beds for elderly and disabled persons and 30 Alzheimer's disease, Category II beds. The census at the time of the survey was 92. Fifteen resident files, three closed records and 12 employee files were reviewed. The facility received a grade of A. Complaint #12640 could not be substantiated. No regulatory deficiencies could be identified. The investigation of Complaint included: Observation of grooming and physical appearance for residents, staff to resident interactions and a tour of the facility. Interviews were conducted with residents, Care Associates, Medication Technician, Wellness Director, Assistant Executive Director, and the Administrator. Clinical Record Review of three closed records including the resident of concern. Document Review included facility policy and procedures, incident report, shower schedules, activities of daily living, and service plans.			
Y 0878 SS= D	NAC 449.2742 5. An over-the-counter medication or a dietary supplement may be given to a resident only if the resident's physician , physician assistant or advanced practice	Y 0878	1. **Resident #4:** Antacid Chew was discontinued by hospice on 4/9/26. **Resident #5:** Hyoscyamine sublingual tablet 0.125mg was reordered from pharmacy and delivered on 4/14/26, placed in medication cart and reconciled with MAR. **Resident #5:** Buspirone tablet was delivered on 4/9/2026, placed in medication cart and reconciled	05/15/2026

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	registered nurse has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician , physician assistant or advanced practice registered nurse. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician , physician assistant or advanced practice registered nurse. The administration of over-the-counter medications and dietary supplements must be included in the record required pursuant to paragraph (b) of subsection 1 of NAC 449.2744. 6. Except as otherwise provided in this subsection, a medication prescribed by a physician, physician assistant or advanced practice registered nurse must be administered as prescribed by the physician, physician assistant or advanced practice registered nurse.. If a physician, physician assistant or advanced practice registered nurse orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order; (2) Indicate on the container of the medication that a change has occurred; and (3) Note the change in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; (b) Within 5 days after the change is ordered, a copy of the order or prescription signed by the physician, physician assistant or advanced practice registered nurse must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; and (c) If the label prepared by a pharmacist does not match the order or prescription written by a physician, physician assistant or advanced practice registered nurse, a physician, registered nurse or pharmacist must interpret that order or prescription and, within 5 days after the change is ordered, the interpretation must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744.		with MAR. **Resident#4:** Physician clarification obtained for Propranolol Hydrochlorothiazide(Hcl) 60 mg capsule formulation discrepancy with hospice clinical team on4/21/26. The prescription was corrected on the MAR on 4/21/26. No doses were administered inconsistently with the clarified order. **Resident #15:** multivitamin tablet was discontinued on 2/24/26. Records show 24 tablets were destroyed on3/6/26. A second card of medications was immediately removed from the cart upon discovery on 4/9/26 and placed in secure medication storage area until it was destroyed on 4/9/26. Residents were assessed and no adverse outcomes were identified. **2**. A complete audit of all residentmedications and MARs was completed on 4/22/26 by Sierra Specialty Pharmacy Pharmacistin collaboration with Cascades Wellness Director and Memory Care Director toensure all ordered medications match physician orders, all MAR documentation isaccurate and complete, and that all medications are onsite. Any discrepanciesidentified were immediately corrected. Audit results will be documented andmaintained for survey review. Training with competency validation for allNurses and Med Techs on the Medication Reconciliation Process at admission andafter physician orders/changes. Focus on verification of medication receiptwithin 24 hours of order and immediate escalation if medication not received, NAC449.2742 requirements, Medication availability expectations, MAR accuracy anddocumentation standards, and Physician order verification. **3.** Weekly cart audits by Wellness Directorand Memory Care Director or designee for four (4) weeks, then monthly audits thereafter.Results will be reviewed in QAPI/clinical meetings. Any discrepancies foundwill result in retraining of employee(s) in violation. A MedicationAvailability Checklist will be put into daily use for each cart at shift changeto be reviewed weekly by Wellness Director and Memory Care	

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	Inspector Comments: Based on observation, clinical record review, interview, and document review, the facility failed to ensure 1) medications were onsite and available for administration for 2 of 15 sampled residents (Resident #4 and #5), and 2) medications were administered as prescribed for 2 of 15 sampled residents (Resident #4 and #15). Findings include: Medications Not Onsite Resident #4 Resident #4 was admitted to the facility on 02/19/2025, with diagnoses including Parkinson's disease and major depressive disorder. A physician's order dated, 01/30/2025 and Resident #4's April Medication Administration Record (MAR), documented Antacid Chew 750 milligram (mg), chew one tablet by mouth every six hours as needed for gastric distress or heartburn. On 04/09/2026 at 2:34 PM, during a review of Resident #4's medications, the Antacid chew was not present. On 04/09/2026 at 2:36 PM, the Medication Technician confirmed the Antacid Chew was listed on the resident's MAR; however, it was not included among Resident #4's medications. Resident #5 Resident #5 was admitted to the facility on 02/10/2026, with diagnoses including Alzheimer's disease and depression. A physician's order dated, 04/08/2026 and Resident #5's April MAR, documented Buspirone 5 mg tablet, take two tablets (10 mg) by mouth twice daily for anxiety disorder.		Director ordesignee. The Administrator will oversee compliance with the monitoring plan. 4. Wellness Director and Memory CareDirector and/or designee and Administrator. 5. Training to becompleted by 5/15/2026.	

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	A physician's order dated 03/13/2026 and Resident #5's April MAR, documented Hyoscyamine Sublingual 0.125 mg, place one tablet under tongue every six hours as needed for terminal congestion. On 04/09/2026 at 2:40 PM, during a review of Resident #5's medications, the Buspirone tablet and Hyoscyamine Sublingual tablet were not present. On 04/09/2026 at 2:42 PM, the Medication Technician confirmed the Buspirone and Hyoscyamine tablets were listed on the resident's MAR; however, the medications were not included among Resident #5's medications. Medications Not Administered as Prescribed Resident #4 Resident #4 was admitted to the facility on 02/19/2025, with diagnoses including Parkinson's disease and major depressive disorder. On 04/09/2026 at 2:34 PM, the following medication was on the medication cart for Resident #4: -Propranolol Hydrochlorothiazide (Hcl) 60 mg capsule, take one capsule by mouth once daily. Resident #4's physician order dated, 07/15/2025 and the April 2026 MAR, documented the following: -Propranolol Hcl extended release 60 mg, take one capsule by mouth once daily. Resident #15 Resident #15 was admitted to the facility on 01/03/2025, with diagnoses including dementia, hypercholesterolemia and chronic obstructive pulmonary disease. On 04/09/2026 at 2:45 PM, the following medication was on the medication cart for Resident #15: -Multivitamin tablet, take one tablet by			

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	mouth once daily. Resident #15's Physician Order dated 05/07/2025, documented the following: - Multivitamin tablet, take one tablet by mouth once daily. Resident #15's April MAR lacked documentation for the Multivitamin tablet. On 04/09/2026 at 2:50 PM, the Medication Technician explained Resident #4's Propranolol on the cart was not an extended release and verbalized the medication needed to match the physician's order. The Medication Technician confirmed Resident #15's multivitamin was not documented on the April MAR and was unable to determine if the Multivitamin tablet was being administered to Resident #15 per the physician's order. Severity: 2 Scope: 1			
Y 0890 SS= A	NAC 449.2744 **Administration of medication: Maintenance of logs and records; contents.** 1. The administration of a residential facility that provides assistance to residents in the administration of medications shall maintain: (a) A log for each medication received by the facility for use by a resident of the facility. The log must include: (1) The type and quantity of medication received by the facility; (2) The date of its delivery; (3) The name of the person who accepted the delivery; (4) The name of the resident for whom the medication is prescribed; and (5) The date on which any unused medication is removed from the facility or destroyed. (b) A record of the medication administered to each resident. The record must include: (1) The type of medication administered;	Y 0890	**1. Resident#12:** Thiamine 100 mg daily was on the MAR listed as its common name of Vitamin B-1 Tab 100 MG and was given on 4/7/26 – 4/9/26 as ordered. Resident moved in on 4/6/26 at 10:15AM. Medication naming discrepancy identified and Med Techs will be re-trained. **Resident #12:** Antacid Calcium 500 mg PRN was added to the MAR on 4/21/26 and will be administered as ordered going forward. Medication Technician will be re-educated and competency validated no later than 5/15/26. Residents were assessed and no adverse outcomes were identified. **2.** Acomplete audit of all resident MAR to physician orders was completed on 4/22/26by Sierra Specialty Pharmacy Pharmacist in collaboration with Cascades WellnessDirector and Memory Care Director to ensure all active orders are reflected onMAR and no medications are present without MAR documentation. Discrepancies werecorrected immediately. Audit results will be documented and maintained forsurvey review. MAR documentation	05/15/2026

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	(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, physician assistant or advanced practice registered nurse, including, without limitation, whether the medication is to be administered according to a routine schedule or as needed; (5) Any change in an order or prescription of a resident's physician, physician assistant or advanced practice registered nurse, including, without limitation, the discontinuation of the medication; (6) Any time when the resident is out of the facility; and (7) Any mistakes made in the administration of medication. (Cross-reference to NAC 449.2742(5)) 2. The administrator of the facility shall keep a log of caregivers assigned to administer medications that indicates the shifts during which each caregiver was responsible for assisting in the administration of medication to a resident. This requirement may be met by including on a resident's medication sheet an indication of who assisted the resident in the administration of the medication, if the caregiver can be identified from this indication. Inspector Comments: Based on observation, document review, and interview, the facility failed to ensure a resident's medication was included on the resident's Medication Administration Record (MAR) for 1 of 15 sampled residents (Resident#12). Findings include: Resident #12		process requirements per NAC 449.2744 will bere-trained with emphasis that no medication may be placed on cart without MARentry verification. All new orders must be entered and double checked within 24hours by nurses or designee. 3. Weeklycart audits with MAR verification by Wellness Director and Memory Care Directorand/or designee for four (4) weeks, then monthly audits thereafter. Resultstracked and trended in QA meeting. TheAdministrator will oversee compliance with the monitoring plan. 4. WellnessDirector and Memory Care Director and/or designee and Administrator. 5. Training to be completed by 5/15/26.	

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	Resident #12 was admitted to the facility on 04/06/2026 with diagnosis of hypertension, hypothyroidism and hyperglyceridemia. A physician's order dated 03/08/2026, included thiamine 100milligrams (mg), oral daily and antacid calcium 500 mg oral every 6 hours as needed for indigestion. The medications were available on the medication cart, but not listed on the facility MAR. On 04/09/2026 at 12:58 PM, the Medication Technician (MT) confirmed the thiamine and antacid calcium were on the medication cart; however, were not listed on the MAR. On 04/09/2026 at 3:10 PM, the Wellness Director (WD) confirmed the MAR was not accurate and the thiamine and antacid calcium should have been included on the facility MAR. Severity: 1 Scope: 1			