STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	370	A. BUILDING _____ B. WING _____	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIERRA PLACE RETIREMENT COMMUNITY	1111 W COLLEGE PARKWAY, CARSON CITY, NEVADA ,89703

(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
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 completed in your facility on 03/25/2026. The census at the time of the survey was 67. The sample size was five and three closed records reviewed. There was one complaint investigated. Complaint #NV00074819 was substantiated. (See Tags Y0598) The investigation of Complaint included: Observation of staff to resident interaction and a tour of the facility. Interviews were conducted with residents, Caregivers, Medication Technician, Wellness Director, Resident Care Director, and Administrator. Clinical Record Review of eight records, which included the resident(s)/ patient(s) of concern. Document Review included facility policy and procedures, incident report, code status, caregiver training, and in-services.			
Y 0590 SS= D	NAC 449.268 **Rights of residents; procedure for filing grievance, complaint or report of incident; investigation and response.** 1. The administrator of a residential facility shall ensure that:	Y 0590	Y0590: Resident #1 moved into Sierra Place on 3/10/23 with a diagnosis including dementia cerebral atherosclerosis. The resident was admitted to hospice services 5/30/25. A signed POLST was in place indicating the resident's wishes for Allow Natural Death (Do Not Attempt Resuscitation) and no medical interventions. On the date of the incident, care staff checked on resident #1 at 2:56 am and found the resident unresponsive. CPR was	08/15/2025

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	(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; (b) A resident is not prohibited from speaking to any person who advocates for the rights of the residents of the facility; (c) The residents are treated with respect and dignity; (d) The facility is a safe and comfortable environment; (e) Residents are not prohibited from interacting socially; (f) Residents are allowed to make their own decisions whenever possible; (g) Residents are aware that they may file a complaint or grievance with the administrator and that a resident who files such a complaint receives a response in a timely manner; (h) A resident is informed as soon as practicable that he is being moved to a new room or that he is receiving a new roommate; and (i) Residents are afforded the opportunity to initiate an advance directive or power of attorney for health care and that the employees of the facility comply with the wishes contained in such a document. 2. The administrator of a residential facility shall provide a procedure to respond immediately to grievance, incidents and complaints. The procedure must include a method for ensuring that the administrator or a person designated by the administrator is notified of the grievance, incident or complaint. The administrator or a person designated by the administrator shall personally investigate the matter. A resident who files a grievance or complaint or reports an incident pursuant to this subsection must be notified of the action taken in response to the grievance,		initiated and 911 was contacted. Upon arrival, paramedics located the residents DNR / POLST, and all life-sustaining measures were immediately discontinued in accordance with the resident's documented wishes. Following the incident, the community identified a deficiency related to staff awareness and response to POLST/DNR directives. Corrective actions were promptly implemented as outlined below: * Training on POLST / DNR protocols was conducted on 8/15/25. (see attached documentation) * Training on Hospice procedures, including when to contact hospice services, was conducted 2/24/26 (see attached documentation) * The Wellness Director or designee provides ongoing education to care staff regarding: *Reviewing resident care plans *Identifying residents on hospice *Understanding when to contact hospice *Locating and verifying POLST/DNR forms and code status *Next scheduled education to be completed 4/28/26 at 3pm *Training is incorporated into new hire orientation and reenforced monthly during staff meetings. * Next monthly training to be completed on 4/28/26 at 3pm * The communication board is reviewed weekly by the resident care coordinator to ensure accuracy and current information. The deficiency was identified at the time of the incident and corrective training was initiated and completed on 8/15/25.	

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	complaint or report or be given a reason why no action needs to be taken. 3. The employees of the facility shall comply with the procedures adopted pursuant to subsection 2. Inspector Comments: Based on interview, clinical record review, and document review, the facility failed to ensure employees complied with the wishes contained in a resident's advance directive and initiated cardiopulmonary resuscitation (CPR) on a resident who had a Do Not Resuscitate (DNR) order in place for 1 of 8 sampled residents (Resident #1). Findings include: Resident #1 Resident #1 was admitted to the facility on 03/10/2023, with diagnoses including dementia and cerebral atherosclerosis. Resident #1's clinical record documented a Nevada POLST (Physician Order for Life-Sustaining Treatment), signed and dated by Resident #1, on 05/30/2025 checked the box to allow natural death (do not attempt resuscitation) as well as requesting no medical interventions. The facility document titled "Advanced Directive Authorization," signed and dated by Resident #1 on 03/10/2023, documented the facility recognizes each resident's right to decide which medical procedure the may or may not wish to undergo. A Do Not Resuscitate form, approved by the state of residence, must be completed and in the resident's file if the resident does not wish to be resuscitated. On 03/25/2026 at 11:24 AM, the Wellness Director explained an emergency binder was kept at the front desk and if a resident had a POLST, it would be located on the resident's refrigerator or behind their			

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	apartment door in a red envelope. The Wellness Director confirmed it would not be appropriate to perform CPR on a resident with a DNR and verified Resident #1 had a POLST indicating DNR status. On 03/25/2026 at 11:34 AM, the Administrator explained POLST forms were kept on resident refrigerators or the backs of their doors, and staff had access to the information on residents' code status through the medication room white board. The Administrator confirmed it was the resident's right to refuse CPR, and verbalized CPR should not be performed on a resident with a DNR order. The Administrator explained on the date of the incident an employee did not handle the situation appropriately and performed CPR on Resident #1 despite the existing DNR. On 03/25/2026 at 11:42 AM, the Resident Care Coordinator explained Resident #1 was found unresponsive in the resident's restroom and staff began CPR without checking the resident's code status. Staff initiated a 911 call. When Emergency Medical Services arrived, they located the resident's DNR in the room and discontinued all life-sustaining measures. The Resident Care Coordinator verbalized Resident #1 was on hospice services and staff did not notify the hospice nurse until after the incident. A facility In-Service training related to POLSTs and DNRs had been conducted on 08/15/2025. The facility document titled "Attachment C – Resident Rights," revised 01/2026, documented the resident shall have the personal right to participate in discussion about care, treatment and access to records. Complaint #NV00074819 Severity: 2 Scope: 1			