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
	1774	A. BUILDING _____ B. WING _____	07/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE LAS VEGAS	**3025 E RUSSELL ROAD, LAS VEGAS, NEVADA ,89120**

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual and infection control State Licensure survey initiated at your facility on 07/19/22, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 105 Residential Facility for Group beds for elderly and disabled persons and/or persons with mental illness and/or persons with Alzheimer's disease and assisted living services, 89 Category 1 and 16 Category II residents. The census at the time of the survey was 52. Fifteen resident files and ten employee files were reviewed. The facility received a grade of C. 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 investigations, 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		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	Name: HEATHER LANKFORD	Title: Executive Director	Date: 08/01/2022

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0050 SS= F	Administrator's Responsibilities - Oversight - NAC 449.194 Responsibilities of administrator. (NRS 449.0302) The administrator of a residential facility shall: 1. Provide oversight and direction for the members of the staff of the facility as necessary to ensure that residents receive needed services and protective supervision and that the facility is in compliance with the requirements of NAC 449.156 to 449.27706, inclusive, and chapter 449 of NRS. Inspector Comments: Based on observation, interview, and document review, the facility failed to ensure safe infection control practices were maintained in response to the COVID-19 Pandemic. Findings include: On 07/19/22 at 9:00 am, the Administrator indicated six residents were positive for COVID-19. A tour of the facility revealed four rooms with Personal Protective Equipment (PPE) bins outside the door. Two of the four rooms lacked a PPE donning/doffing poster (Room #45 & #54). In addition, four rooms' PPE bins lacked the appropriate PPE to enter resident rooms. - Room #2's PPE bin had zero face shields. - Room #22's PPE bin had zero face shields. - Room #45's PPE bin had zero face shields. - Room #54's PPE bin had zero face shields and zero N95 masks. On 07/19/22 at 10:00 am, the PPE donning/doffing poster on Room #2 and #22, documented N95 masks and face shields were required to enter the rooms of COVID-19 positive residents. The Administrator and Health and Wellness Coordinator acknowledged Room #45 and #54 lacked a PPE donning/doffing poster. The Administrator and Health and Wellness Coordinator acknowledged the PPE bins in front of the rooms of COVID-19 positive residents lacked the required PPE. Severity 2 Scope 3	0050	0050 SS=F 1. PPE donning/doffing posters were affixed to the doors of rooms #45 & #54. Face shields were added to the PPE carts at rooms #2 & #22 & #45 & #54. N95 masks were added to the PPE cart at room #54. These corrections were made on 07/19/2022. 2. Med-Tech's and Caregivers have been in-serviced on PPE usage required when providing services for positive residents. Also in-serviced on where additional PPE is stored and how to access it if a cart does not have the appropriate PPE. 3. Med-Tech's will audit PPE carts of positive Residents at the start and end of their shifts. They will re-stock carts as necessary and ensure that the PPE donning/doffing poster remains affixed to the doors of those residents that are positive. 4. Health & Wellness Director & Executive Director will monitor for compliance. 5. July 21, 2022	07/21/2022

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0178 SS= F	Health & Sanitation - Maintain Int/ext - NAC 449.209 Health and sanitation. (NRS 449.0302) 5. The administrator of a residential facility shall ensure that the premises are clean and that the interior, exterior and landscaping of the facility are well maintained. Inspector Comments: Based on observation and interview, the facility failed to ensure the interior and exterior of the facility was maintained. Findings include: On 07/19/22 in the morning, the following was observed in the Memory Care unit: The lock on a kitchen cabinet under the sink did not fit correctly when in the lock position and the cabinet could still be opened. In the common area bathroom, the toilet seat was not secured and would shift left to right when being used. In the courtyard adjacent to the dining area there were weeds in excess of 12 inches of height. On 07/19/22 in the morning, Memory Care Coordinator acknowledged the lock on the kitchen cabinet door would not lock, the toilet seat in the common area bathroom was not secured properly, and there were high weeds in the court yard. Severity: 2 Scope: 3	0178	0178 1. On 07/19/2022 contents of the kitchen cabinet under the sink that were cleaning chemicals were removed and placed into a locked storage room that contained other chemicals and common area bathroom toilet seat was repaired. On 07/21/2022 landscapers cut the weeds in the Memory Care courtyard. 2. Staff have been in-serviced to identify potential safety hazards and weeds and to being those items to the attention of the Clare Bridge Program Coordinator and/or Executive Director immediately. Also instructed on how to report and have a work order generated by the administrative staff. 3. Clare Bridge Program Coordinator & Executive Director will monitor areas in the Memory Care to identify potential hazards when doing daily walk throughs. 4. Clare Bridge Program Coordinator & Executive Director will monitor for compliance. 5. 07/21/2022	07/21/2022

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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 07/19/2022, the facility failed to ensure the kitchen and supportive dining services complied with the standards of NAC 446. Findings include: 1. Critical Violations: a. In the reach-in cooler, two containers of yogurt were expired 06/03/22 & 06/11/22, two containers of cottage cheese were expired 07/13/22, and a container of key lime juice was expired 05/23/22. b. In the walk-in cooler, fruit topping was expired 07/15/22, and two containers containing raw chicken were expired 07/11/22 & 07/17/22. 2. Major Violations: a. In the walk-in cooler, multiple items were not labeled or dated to indicate when they were prepared such as hot dogs, mustard and bean soup. b. The cook's line ventilation hood had heavy grease and dust build-up. c. The ventilation hood over the dish machine had heavy dust build-up. d. The can opener was soiled with debris and metal shavings. e. The floors throughout the kitchen and serving kitchen were soiled with food and debris under equipment, shelving units and tables. 3. Equipment and Maintenance Violations: a. The front panel of the deep fat fryer was not installed and grease/dust build-up was accumulating on the internal components of the fryer. Severity: 2 Scope: 3	0255	0255 1. On 07/19/2022 two containers of yogurt, two containers of cottage cheese, one container of key lime juice, fruit topping and two containers of raw chicken were disposed of due to being past the expiration date. Also disposed of were hotdogs, mustard and bean soup which were not labeled or dated. The cooks line hood and dish machine hood was professionally cleaned on 07/26/2022. The can opener was cleaned on 07/19/2022. On 07/29/2022 the floors in the kitchen and the serving kitchen were power washed. The front panel of the fryer was put back into place on 07/19/2022 and the interior components were cleaned.. 2. On 07/20/2022 & 07/21/2022 dietary staff were in-serviced on expired foods, dating and labeling of foods and floor cleaning. 3. Cooks will check the refrigerators daily to ensure that all food items inside are labeled and dated and that that there are no expired food items. 4. Dietary Services Manger & Executive Director will monitor for compliance. 5. 07/29/2022	07/29/2022

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0273 SS= D	Nutrition and Service of Food - Special Diet - NAC 449.2175 4. A resident who has been placed on a special diet by a physician or licensed dietitian must be provided a meal that complies with the diet. The administrator of the facility shall ensure that records of any modifications to the menu to accommodate for special diets prescribed by a physician or licensed dietitian are kept on file for at least 90 days. Inspector Comments: Based on interview, record review, and document review, the facility failed to provide special diets for 2 of 15 sampled residents (Resident #8, #15). Findings include: Resident #8 (R8) R8 was admitted to the facility on 09/02/21 with diagnoses including chronic kidney disease stage 3, glaucoma, and dementia. The physician's statement dated 08/31/21 documented R8 required a special 2 gram sodium diet. Resident #15 (R15) R15 was admitted to the facility on 07/15/21 with diagnoses including pre-diabetic and dementia. The physician's statement dated 08/17/21 documented R15 required a special 2 gram sodium diet. On 07/19/22 at 11:00 AM, the Dietary Manager indicated the lunch meal included Salisbury steak, fried chicken, scalloped potatoes, and butter noodles. The Dietary Manager indicated being unaware R8 and R15 needed a special 2 gram sodium diet. At 12:00 PM, the Administrator, the Dietary Manager, and the Wellness Director confirmed they were not aware R8 and R15 needed a 2 gram sodium diet. The Administrator and the Dietary Manager verified the lunch meal served to the two residents exceeded the 2 grams of sodium. The Dietary Manager and the Lead Caregiver indicated if a resident needed a special diet, the physician's documentation was supposed to be forwarded to the Dietary Manager and kept in a binder. The Dietary Manager confirmed there was no documented communication in the special diet binder for R2 and R15. Severity: 2 Scope: 1	0273	0273 1. On 07/19/2022 Diet Book was updated with physician's diet order for Resident #8 & #15. 2. Dietary book was reviewed with the Health & Wellness Director and Dining Services Manger to ensure all diet orders of all Residents were in the book. A dietary log of those Residents on diets other than regular was posted in the serving kitchen. Dietary staff will ensure that the residents on a special diet receive the correct meal to match that diet for that meal period. 3. Dietary Services Manager and Health & Wellness Director will update diet book upon new admissions and change of diets by physician orders and will audit diet book once a month for compliance. Dietary staff and Clinical staff have been in-serviced on special diets. 4. Dining Services Manager and Health & Wellness Director will monitor for compliance. 5. 07/21/2022	07/21/2022

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0859 SS= D	Medical Care of Resident After Illness - NAC 449.274 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 his or her physician. The resident must be cared for pursuant to any instructions provided by the resident ' s physician. Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 15 sampled residents had an annual physical exam. Resident #13's last physical exam was dated 01/25/21. The Wellness Director indicated the resident did not have an updated physical exam. Severity: 2 Scope: 1	0859	0859 1. Dr. wants to see Resident #13 in office. Appointment was made for 08/29/2022 at 10:00AM and her son will take her to the appointment with the History & Physical forms to be completed while at the office visit. 2. HWD (Health & Wellness Director) has a tickler to send out annual History & Physical forms to providers a month in advance of the due date. She will also follow up to ensure that the provider has a date scheduled to see the Resident. 3. HWD will audit Annual History & Physical tickler on a monthly basis to ensure that we are compliant. 4. HWD & Executive Director will monitor for compliance. 5. 08/29/2022	08/29/2022

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0876 SS= D	Medication Administration - NRS 449.0302 - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. (as amended by LCB File No. R109-18) 4. Except as otherwise provided in this subsection, a caregiver shall assist in the administration of medication to a resident if the resident needs the caregiver's assistance. A caregiver may assist the ultimate user of: (a) Controlled substances or dangerous drugs only if the conditions prescribed in subsection 6 of NRS 449.0302 are met. (b) Insulin using an auto-injection device only if the conditions prescribed in NRS 449.0304 and section 13 of this regulation are met. Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 15 sampled residents had an updated ultimate user agreement. Resident #15's ultimate user agreement indicated self-medicating. The resident started on the facility's medication program on 07/15/21, and had no updated ultimate user agreement. The Administrator and the Wellness Director acknowledged the ultimate user agreement was not updated and should have been. Severity: 2 Scope: 1	0876	0876 1. Responsible party of Resident #15 signed Ultimate User Agreement, consent for Brookdale to assist with medications. Date signed 07/26/2022. 2. HWD (Health & Wellness Director) has a tickler reminder to get an updated Ultimate User Agreement signed when an ADL assessment/Care Plan is changed to include Medication Management care services. 3. HWD will audit Medication Management Care Services on a monthly basis to ensure signed Ultimate User Agreements are in the Resident file. 4. HWD & Executive Director will monitor for compliance. 5. 07/26/2022	07/26/2022

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0991 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: (b) Operational alarms, buzzers, horns or other audible devices which are activated when a door is opened are installed on all doors that may be used to exit the facility. Inspector Comments: Based on observation and interview, the facility failed to ensure an audible alarm system was activated on a door exiting to an outdoor courtyard. Finding include: On 07/19/22 in the morning, during a tour of the facility, the audible alarm on a door to the outdoor courtyard was observed set in the off position. The alarm did not sound when the door was opened. The Memory Care Coordinator switched the alarm to the on position and the alarm did not sound when the door was opened. On 07/19/22 in the morning, The Memory Care Coordinator acknowledged the audible alarm did not function when the door opened to the outdoor courtyard. Severity: 2 Scope: 3	0991	0991 1. On 07/19/2022 Memory Care Coordinator replaced the battery in the door alarm leading from the dining room to the memory care courtyard. 2. On 07/19/2022 memory care staff were in-serviced on the Alarm Doors in the memory care unit. Door alarms will be checked daily by the Med Tech's and/or the Clare Bridge Program Coordinator (Memory Care Director). Door alarms will not be turned to the "Off" position. Door alarms will be checked by ensuring the alarm position is on and that the battery is working. 3. Med Tech assigned to the Memory Care Unit will check the alarm at the start and end of their shift to ensure the position of the alarm is on and the battery is working. 4. CBPC (Clare Bridge Program Coordinator) & Executive Director will monitor for compliance. 5. 07/19/2022	07/19/2022

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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 with diagnoses of Alzheimer's disease and/or dementia. Findings include: On 07/19/22 in the morning, observed a cabinet underneath a sink in the dining area was unlocked, inside the cabinet was a bottle of furniture polish and other cleaning chemicals. On 07/19/22 in the morning, the Memory Care Coordinator acknowledge the cleaning supplies should have been secured. Severity: 2 Scope: 3	0999	0999 1. On 07/19/2022 furniture polish and other cleaning chemicals were removed from the kitchen cabinets and placed in a locked storage room which stores other chemicals in the Memory Care. Please see attached pictures. 2. We have permanently changed the location of all chemicals that were stored in the kitchen cabinets to the locked storage room which stores other chemicals in the Memory Care. Staff have been in-serviced to know the procedures on where to properly store chemicals. 3. CBPC (Care Bridge Program Director) and Med Tech's will check kitchen area cabinets to ensure that no chemicals are stored there and are in the designated locked storage room on a shift to shift basis. 4. CBPC & Executive Director will monitor for compliance. 5. 07/19/2022	07/19/2022