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
	1884	A. BUILDING _____ B. WING _____	10/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE RENO	3105 PLUMAS STREET, RENO, NEVADA ,89509

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a State Licensure annual grading survey conducted at your facility on 10/24/22. This survey was conducted by the Division of Public and Behavioral Health in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 56 Residential Facility for Group beds, assisted living services for elderly and disabled persons, and/or persons with Alzheimer's disease, Category II residents. The census at the time of the survey was 36. 10 resident files were reviewed and 10 employee files were reviewed. The facility received a grade of C. 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. 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. The following regulatory deficiencies were identified:	0000		
0885 SS= D	Medication - Destruction - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 9. If the medication of a resident is discontinued, the expiration date of the medication of a resident has passed, or a resident who has been discharged from the facility does not claim the medication, an employee of a residential facility shall destroy the	0885	This particular medication was immediately destroyed at time of survey. Weekly medication cart audits have been scheduled every Wednesday, effective 02/01/2023, to ensure all medications are correct and up to date. This will be done by the Resident Care Coordinator and will be monitored by the Health and Wellness Director.	02/01/2023

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	medication, by an acceptable method of destruction, in the presence of a witness and note the destruction of the medication in the record maintained pursuant to NAC 449.2744. Inspector Comments: Based on observation, interview, and clinical record review, the facility failed to ensure a discontinued medication was destroyed for 1 of 10 residents (Resident #8). Findings include: Resident #8 Resident #8 was admitted to the facility on 06/25/21, with diagnoses including vascular dementia with Alzheimer's disease and vitamin D deficiency. A physician's order for Resident #8 dated 08/23/21, documented acetaminophen 325 milligrams (mg), take two tablets (650 mg) by mouth twice a day for pain. Discard on 08/23/22. The medications for Resident #8 included a bottle of acetaminophen 325 milligrams (mg), take two tablets (650 mg) by mouth twice a day for pain. The medication was not identified on Resident #8's MAR dated October 2022. A physician order dated 08/25/21, documented the acetaminophen 325 mg tablet, take two tablets by mouth twice a day for pain should have been discontinued. On 10/24/22 at 12:50 PM, the Medication Technician confirmed the acetaminophen should have been discarded on 08/23/22. The medication should have been pulled out of the cart so the medication was not administered to the resident. On 10/24/22 at 12:55 PM, the Medication Technician verbalized medications discontinued or expired would be pulled from the cart, signed off by two people, and placed in a special bucket in the facility for destruction. The facility policy title, "Disposal/Destruction of Expired or Discontinued Medications," revised 01/01/13, documented the medication container should be secured in a locked cabinet until it is disposed of, or picked up by a licensed waste disposal company. Severity: 2 Scope: 1			

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0905 SS= D	Administration of Medication Restrictions - NAC 449.2746 Administration of medication: Restrictions concerning medication taken as needed by resident; written records. (NRS 449.0302) 1. A caregiver employed by a residential facility shall not assist a resident in the administration of a medication that is taken as needed unless: (a) The resident is able to determine his or her need for the medication; (b) The determination of the resident ' s need for the medication is made by a medical professional qualified to make that determination; or (c) The caregiver has received written instructions indicating the specific symptoms for which the medication is to be given, the exact amount of medication that may be given and the frequency with which the medication may be given. Inspector Comments: Based on record review, document review and interview, the facility failed to ensure written instructions indicating the specific symptom(s) for which an as needed (PRN) medication was to be given was documented for 1 of 10 sampled residents (Resident #7). Findings include: Resident #7 Resident #7 was admitted to the facility on 06/01/22, with diagnoses including vascular dementia, tremor, atrial fibrillation, and sequelae of cerebral infarction. Resident #7's Medication Administration Record (MAR) dated October 2022, documented ondansetron HCL tablet 4 milligrams (mg), take 4 mg by mouth every six hours as needed. The ondansetron lacked the reason to give the medication. Resident #7's physician order dated 06/17/22, documented ondansetron HCL tablet 4 milligrams, take 4 mg by mouth every six hours as needed. The physician order lacked the reason to give the medication. On 10/24/22 at 12:40 PM, the Medication Technician confirmed Resident #7's MAR and physician order for ondansetron HCL lacked the specific reason to administer the medication. The Medication Technician verbalized staff would not know why to give the medication and would need to get a clarification from the physician. Severity: 2 Scope: 1	0905	A new order for this resident was obtained immediately after time of survey to include reasoning of what medication is needed for. Brookdale Reno is reviewing all residents who have "as needed" medication to change to a scheduled medication or destroy and discard if no longer needed and ensure proper documentation orders are clarified. The prn medications will also be checked every Wednesday as part of the weekly medication cart audit, effective 02/01/2023, to ensure all prn medications state the reasoning of what the medication is needed for. This will be done by the Resident Care Coordinator and will be monitored by the Health and Wellness Director.	02/01/2023

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0923 SS= D	Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 3. Medication, including, without limitation, any over-the-counter medication or dietary supplement, must be: (a) Plainly labeled as to its contents, the name of the resident for whom it is prescribed and the name of the prescribing physician; and (b) Kept in its original container until it is administered. Inspector Comments: Based on observation, clinical record review, and document review, the facility failed to ensure an over-the-counter medication had a resident name and/or ordering physician's name on the label for 2 of 10 sampled residents (Resident #5 and #9). Findings include: Resident #5 Resident #5 was admitted to the facility on 09/22/22 with diagnoses including Alzheimer's disease, hyperlipidemia, hypertension and lower back pain. Resident #5's Medication Administration Record (MAR) dated October 2022, documented Calcium 600 oral tablet, give one tablet by mouth one time a day for supplement. The medication was located in Resident #5's medication bin, however, lacked documented evidence of the resident's name and the ordering physician's name on the medication. On 10/24/22 at 12:30 PM, the Medication Technician confirmed the Calcium 600milligram (mg) did not have the name of the resident and ordering physician on the medication bottle. Resident #9 Resident #9 was admitted to the facility on 06/26/22, with diagnoses including dementia, and epilepsy. Resident #9's October 2022 Medication Administration Record (MAR) documented Aspirin 81 mg take one tablet by mouth once a day. The medication was located in Resident #9's medication bin, however, lacked documented evidence of the physician's name on the medication. On 10/24/22 at 1:44 PM, a Medication Technician confirmed the Asprin 81 mg did not have the name of the ordering physician on the medication bottle. Severity: 2 Scope: 1	0923	All over the counter medications have been labeled with resident's name and ordering physician as of 02/01/2023. All over the counter medications will be checked as part of the weekly medication cart audit to ensure all over the counter medications are labeled with residents name, ordering physician and ending orders. The Resident Care Coordinator will be responsible and will be monitored by the Health and Wellness Director.	02/01/2023

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0994 SS= E	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: (e) Knives, matches, firearms, tools and other items that could constitute a danger to the residents of the facility are inaccessible to the residents. Inspector Comments: Based on observation and interview, the Administrator failed to ensure dangerous items were not stored in resident rooms endorsed for the care of residents with Alzheimer's disease. Findings include: On 10/24/22 between 10:12 AM and 11:14 AM, the following items were observed in resident rooms: Room 14 - a nail file with a pointed end was in the bathroom cabinet Room 21 - butterfly pins were attached to a curtain and a blow dryer and a hair straightening iron were the bathroom cabinet Room 20 - tweezers were in a drawer Room 25 - a light bulb was in a drawer Room 28 - nail clippers were in a drawer Room 39 - a curling iron was in the room On 10/24/22 at each discovery, the Health and Wellness Director confirmed the dangerous items were located in resident rooms and verbalized all of the items should have been secured from the residents to keep the residents safe. Severity: 2 Scope: 2	0994	All dangerous items were immediately removed from each residents room at time of survey and stored properly. Resident room checks will be done frequently by all staff members to ensure there are no dangerous items in each residents room. Staff in service to be completed no later than 02/10/2023 to educate staff on what dangerous items are. The staff in service will be instructed by the Health and Wellness Director and will be monitored by the Executive Director	02/10/2023

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0999 SS= E	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, interview, and document review, the failed to ensure toxic substances were not stored in resident rooms endorsed for the care of residents with Alzheimer's disease. Findings include: On 10/24/22 between 10:12 AM and 11:14 AM, the following toxic substances were observed in resident rooms: Room 14 - body wash, face cream, adult toothpaste, and lotion were in the unlocked bathroom cabinet. Room 16 - lotion, shampoo, deodorant, and mouthwash were in the unlocked bathroom cabinet. Room 19 - adult toothpaste was on the toilet. Room 21 - toothpaste, body wash, and diaper cream were in the unlocked bathroom cabinet. Room 22 - anti-aging serum was in a drawer and cosmetics, lotion, and toothpaste were in the unlocked bathroom cabinet. Room 23 - air freshener and body spray were in the closet and adult toothpaste, body cream, rubbing alcohol, multipurpose cleaner, and air freshener were in the unlocked bathroom cabinet. Room 25 - bar soap was in the unlocked bathroom cabinet. Room 44 - cosmetic powder was in the unlocked bathroom cabinet. On 10/24/22, the Executive Director (other facility) was present at each discovery and verbalized the items should not be stored in resident rooms. Severity: 2 Scope: 2	0999	All toxic items have been removed from the residents room and stored properly as of 02/01/2023. Room checks will be done frequently by all staff members to ensure there are no dangerous/ toxic items in each residents room. Staff in service to be completed no later than 02/10/2023 to educate staff on what toxic items are. The staff in service will be instructed by the Health and Wellness Coordinator and will be monitored by the Executive Director.	02/10/2023

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0179 SS= D	Health & Sanitation - Screens - NAC 449.209 Health and sanitation. (NRS 449.0302) 6. All windows that are capable of being opened in the facility and all doors that are left open to provide ventilation for the facility must be screened to prevent the entry of insects. Inspector Comments: Based on observation and interview, the facility failed to ensure a resident's room (Room #25) had a screen covering an opened window. Findings include: On 10/24/22 at 11:40 AM, resident Room #25's window was opened and lacked a screen. On 10/24/22 at 11:40 AM, the Maintenance Manager confirmed the window lacked a screen. Severity: 2 Scope: 1	0179	The window screen was immediately replaced on the residents room at time of survey. The Maintenance Manager will do a daily walkthrough of the property, effective 01/01/2023, to ensure all window screens are on each window and ensure the safety of all residents. This will be monitored by the Executive Director.	01/01/2023
0457 SS= E	First Aid & CPR - NAC 449.231 First aid and cardiopulmonary resuscitation. (NRS 449.0302) 3. Except for first aid in an emergency, no treatment or medication may be administered to a resident without the approval of a physician. Inspector Comments: Based on record review, document review and interview, the Administrator failed to ensure the facility had a physician order for facility licensed staff to administer tuberculosis (TB) tests to 3 of 10 residents (Resident #5, #7, and #2). Findings include: Resident #5 Resident #5 was admitted to the facility on 09/22/22 with diagnoses including Alzheimer's disease, hyperlipidemia, hypertension and lower back pain. Resident #5's clinical record documented a first-step TB test given 09/23/22 and read negative on 09/27/22 and a second step TB test given on 09/30/22 and read negative on 10/03/22. Both 2-step TB tests were given at the facility by the Health and Wellness Director (HWD). Resident #7 Resident #7 was admitted to the facility on 06/01/22 with diagnoses including vascular dementia, tremor, atrial fibrillation and sequelae of cerebral infarction. Resident #7's clinical record documented a first step TB test given on 06/02/22 and read negative on 06/05/22 and a second step TB test given on 06/08/22 and read negative on 06/10/22. Both 2-step TB tests were given at the	0457	Brookdale Reno will obtain physicians order for all residents who need a TB placed. The Health and Wellness Director will be responsible for this and will be monitored by the Executive Director.	02/01/2023

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	facility by the HWD. On 10/24/22 at 11:50 AM, the HWD confirmed the HWD had given the TB tests to Residents #5 and #7 and verbalized the HWD did not have an order to administer the TB tests. Resident #2 Resident #2 was admitted to the facility on 03/22/22 with diagnoses including dementia, hyperlipidemia, and high cholesterol. Resident #2's clinical record documented a first step TB test given on 03/03/22 and read negative on 03/06/22 and a second step TB test given on 03/10/22 and read negative on 03/13/22. Both 2-step TB tests were given at the facility by the HWD. On 10/24/22 at 11:03 AM, the HWD confirmed the HWD had given the TB tests to Residents #2 verbalized the HWD did not have an order to administer the TB tests. Severity: 2 Scope: 2			
0874 SS= E	Medication Administration-Report Received - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 2. Within 72 hours after the administrator of the facility receives a report submitted pursuant to paragraph (a) of subsection 1, a member of the staff of the facility shall notify the resident's physician of any concerns noted by the person who submitted the report. The report must be reviewed and initialed by the administrator. Inspector Comments: Based on record review, document review and interview, the Administrator failed to 1) notify a resident's physician of the pharmacist's recommendation and/or 2) initial the medication profile review within 72 hours for 3 of 10 sampled residents (Resident #8, #9, and #10). Findings include: Resident #8 Resident #8 was admitted to the facility on 06/25/21, with diagnoses including vascular dementia with Alzheimer's disease and vitamin D deficiency. Resident #8's record contained a six month medication review dated 10/19/22 with a documented therapeutic recommendation. There was no documentation the physician was notified of the pharmacist's recommendation and the medication review lacked a signature or initials of the Administrator. Resident #9	0874	All recommendations have been faxed to each attending physician. All future recommendations will be faxed to each attending physician within 72 hours and signed off. Estimated completion date: 02/10/2023. This will be completed by the Health and Wellness Director and will be monitored by the Executive Director.	02/10/2023

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	Resident #9 was admitted to the facility on 10/08/21, with diagnoses including atrial fibrillation, hypertension and dementia . Resident #9's record contained six month medication review dated 10/19/22 with a documented therapeutic recommendation. There was no documentation the physician was notified of the pharmacist's recommendation and the medication review lacked a signature or initials of the Administrator. Resident #10 Resident #10 was admitted to the facility on 10/04/22, with diagnoses including dementia and prostate cancer. Resident #10's record contained a medication review dated 10/19/22 with a documented therapeutic recommendation. There was no documentation the physician was notified of the pharmacist's recommendation and the medication review lacked a signature or initials of the Administrator. On 10/24/22 at 11:46 AM, the Health & Wellness Director verbalized the medication reviews, dated 10/19/22, lacked evidence of the physician being notified of the pharmacist's recommendation and confirmed the medication review had not been signed or initaled by the administrator within 72 hours. Severity: 2 Scope: 2			
0878 SS= E	Medication/OTCS, Supplements, Change Order - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 5. An over-the-counter medication or a dietary supplement may be given to a resident only if the resident's physician has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician. 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 must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be administered to a resident: (a) The	0878	A change order label was immediately produced for the medication(s). All future medication(s) will have a change order label and will be identified as part of the weekly medication cart audit, effective 02/01/2023. The Resident Care Coordinator will be responsible for the medication cart audit and will be monitored by the Health and Wellness Director.	02/01/2023

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	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 (Previously Y 0879) (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 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, the 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. Inspector Comments: Based on document review, record review, observation and interview, the facility failed to ensure a change order label was completed and a medication was on-site to administer as prescribed for 1 of 10 sampled residents (Resident #10). Findings include: Resident #10 Resident #10 was admitted to the facility on 10/04/22 with diagnoses including dementia and prostate cancer On 10/24/22 at 1:45 PM, during a review of residents' medications, Resident #10 lacked fluticasone propionate nasal suspension 50 micrograms (mcg) and senna 8.6 milligrams (mg). Resident #10's October 2022 MAR and Physician's Order dated 10/04/22, documented the following: -fluticasone 50mcg/inhale one spray into each nostril every 24 hours as needed for allergy symptoms. -senna 8.6 mg, give one tablet by mouth daily as needed for constipation. On 10/24/22 at 1:57 PM, the Medication Technician confirmed the facility lacked Resident #10's fluticasone propionate and senna. Resident #10's physician order, dated 10/04/22 and October 2022 MAR documented tamsulosin 0.4 mg, give one capsule by mouth daily. Resident #10's medication label documented tamsulosin 0.4 mg, give two capsules by mouth daily. On 10/24/22 at 2:02 PM, the Medication			

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	Technician verbalized the medication label should have a change label. Severity: 2 Scope: 1			