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 _____	**03/24/2023**

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 mandatory regrading and complaint investigation, conducted at your facility on 03/06/23 & 03/21/23. This State Licensure Survey was conducted in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 56 Residential Facility for Group beds for elderly and disabled persons and/or persons with Alzheimer's disease, Category II residents. The census at the time of the survey was 33. Six resident files were reviewed. The facility received a re-survey 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. There was one complaint investigated. Complaint #NV00068206 with the allegation the facility was short staffed was substantiated (See Tag Y0593 and Y0966). The following allegations could not be substantiated: Allegation #1: a resident had been raped by another resident could not be substantiated due to lack of evidence. Allegation #2: a resident's room was untidy with trash cans overflowing could not be substantiated due to lack of evidence. Allegation #3: the facility did not respond to complaints filed to the facility could not be substantiated due to lack of evidence. Allegation #4: a resident was left unchanged in soiled breifs for over several hours could not be substantiated	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | Name: KRYSTAL GUERRERO | Title: Executive Director | Date: 04/17/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	due to lack of evidence. The investigation into the allegations included: Observations of resident to staff interactions, resident to resident interactions, facility staff present and resident rooms. Interviews were conducted with the Complaintant, a Resident, Caregivers, Medication Technicians, Housekeeper Supervisor, the Director of Clinical Services, and the Executive Director. Reviewed the resident of concerns record to include Personal Service Plan, staff schedules, daily census of residents, residency agreement, and facility policies to include Change of Condition, Resident Bill of Right, Abuse, Neglect & Exploitation Policy: NV-1, Sercice Plan Precess Policy, Staffing Requirement Policy NV-6, Evaluation Process Policy, Grievance Policy and Procedure, Creating a Fresh Impression: Common Area Cleaning, Fresh Impressions: Resident Apartment Cleaning, and Reportable Events. 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:			
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.	0179	Please refer to the original Statement of Deficiency/Plan of Correction - Event ID ZL6B11	03/06/2023
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.	0457	Please refer to the original Statement of Deficiency/Plan of Correction - Event ID ZL6B11	03/06/2023
0556 SS= D	Provision of Dental, Optical and Hearing Care - NAC 449.262 Provision of dental, optical and hearing care and social services; report of suspected abuse,	0556	The Executive Director (ED) reported event to ADSD on 03/24/2023. This event was	05/17/2023

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	neglect, isolation or exploitation; restrictions on use of restraints, confinement or sedatives. (NRS 449.0302) 2. If an employee of the facility suspects that a resident is being abused, neglected, isolated or exploited, the employee shall report that fact in the manner prescribed in NRS 200.5093. Inspector Comments: Based on record review, document review, and interview, the facility failed to report suspected resident sexual abuse to the Aging and Disabilities Services Division (ADSD) for 1 of 31 residents (Resident #3). Findings include: Resident #1 Resident #1 was admitted to the facility on 11/14/22 with diagnoses including unspecified dementia, Alzheimer's disease, and anxiety. Resident #3 Resident #3 was admitted to the facility on 01/06/23, with diagnoses including unspecified dementia and hypothyroidism. An Incident Report, dated 03/14/23, documented Resident #1 and Resident #3 were found in bed together unclothed, unknown if intercourse had occurred. Resident #1 and Resident #3 were separated, and an investigation was conducted by the Executive Director. A Self Report Form on State of Nevada Division of Public and Behavioral Health (DPBH) letterhead, undated and unknown sent time, documented a resident-to-resident sexual physical contact occurred at 9:40 PM on 03/14/23. This report indicated care staff was doing evening rounds and came into room #42 where Resident #3 was lying in bed naked with Resident #1. Resident #1 was also naked and did have an erection. It is unknown if there was any sexual contact made between the two residents, The contact person listed on the Self Report Form was the facility's Administrator. This report indicated the local sheriff's department and both resident's power of attorney had been contacted. No documented evidence was on file indicating the facility contacted ADSD. Review of the		reported to police, responsible parties and PCP's at time of the incident. Reno community leadership were retrained on the Community's Abuse, Neglect and Exploitation policy, including reporting any suspected abuse, neglect or exploitation to the ADSD and police in a timely manner. Training completed on 03/24/2023. Community associates were retrained on the community's Abuse, Neglect and Exploitation policy, including reporting requirements. Training completed on 03/28/2023. To assist with ongoing compliance, during daily standup with associates, the ED or designee will discuss potential reportable events through 05/17/2023.	

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	facility's policy and procedures, titled Abuse, neglect & Exploitation Policy - NV-1, last revised 05/2021, contained a section specific to Nevada. It specified: If a determination was made there was reasonable cause to believe a resident had been abused, neglected, or exploited, the executive Director or designee should report such information to: 1) The local office of the Aging and Disabilities Services Division of the Department of Health and Human Services. 2) A police department of sheriff's office; or 3) A toll-free telephone service designated by the Aging and Disabilities Services Division of the Department of Health and Human Services. As of 03/14/23, NRS 200.5093 required known and suspected abuse to be reported promptly to: 1) The local office of the Aging and Disabilities Services Division of the Department of Health and Human Services. 2) A police department of sheriff's office; or 3) A toll-free telephone service designated by the Aging and Disabilities Services Division of the Department of Health and Human Services. On 03/21/23 at 11:24 AM, the Executive Director verbalized an unwitnessed case of suspected resident to resident sexual abuse occurred on 03/14/23. The Executive Director discussed reporting the incident the same day to the local sheriff's office and following the facility's policy and procedures on Abuse and Reporting. The Executive Director explained when abuse incidents occurred, the facility followed its policy for reporting abuse. The Executive Director confirmed not contacting ADSD about the incident because the Executive Director was not aware this was required by Nevada State law. Complaint #NV00068206 Severity: 2 Scope: 1			
0593 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	0593	Personal Service Plan for resident #1 was updated to include interventions in the event if sexual expressions/behaviors. Resident # 3 no longer resides at the	05/17/2023

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	administrator of a residential facility shall ensure that: (d) The facility is a safe and comfortable environment; Inspector Comments: Based on record review, document review, and interview, the Administrator failed to ensure the facility provided a safe environment for 2 of 6 sampled residents (Resident #1 and #3). Findings include: Resident #1 Resident #1 was admitted to the facility on 11/14/22, with diagnoses including unspecified dementia, Alzheimer's disease, and anxiety. Resident #3 Resident #3 was admitted to the facility on 01/06/23, with diagnoses including unspecified dementia and hypothyroidism. An Incident Report, dated 03/14/23, documented Resident #1 and Resident #3 were found in bed together unclothed, unknown if intercourse had occurred. Resident #1 and Resident #3 were separated, and an investigation was conducted by the Executive Director. A Self Report Form on State of Nevada Division of Public and Behavioral Health (DPBH) letterhead, undated and unknown sent time, documented a resident-to-resident sexual physical contact occurred at 9:40 PM on 03/14/23. This report indicated care staff was doing evening rounds and came into room #42 where Resident #3 was lying in bed naked with Resident #1. Resident #1 was also naked with physical signs of arousal. It was unknown if there was any sexual contact made between the two residents. The contact person listed on the Self Report Form was the facility's Administrator. This report indicated the local sheriff's department and both residents' Power of Attorney had been contacted. Resident #1's Physician Progress Note dated 12/01/22, documented a Medication Technician reported Resident #1 had demonstrated inappropriate intimate behaviors towards female residents and staff. Resident #1's Temporary Service Plan-Behavioral Expressions dated 12/26/22, documented a specific behavior		community. Resident #1 was relocated to Cottage hallway on 4/2/2023. Reno community leadership were retrained in the Community's Abuse, Neglect and Exploitation policy, including reporting any suspected abuse, neglect or exploitation to the ADSD and police in a timely manner. Training completed 03/24/2023. Community associates were retrained on the community's Abuse, Neglect and Exploitation policy, including reporting requirements, protection of residents and referral for treatment as authorized by legally responsible party. Training completed on 03/28/2023. Community staff will be in-serviced on the community's change of condition policy on 04/25/2023. The community's ED and staff responsible for scheduling were in-serviced on the community's staffing policy. To assist with ongoing compliance, during daily standup with associates, ED or designee will discuss potential reportable events and changes un resident condition through 05/17/2023. To assist with ongoing compliance, the ED or designee with audit staffing schedules for assignments weekly until 05/17/2023 to verify compliance with applicable staffing requirements.	

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	of sexual, aggressive. Resident #1's Personal Service Plan dated 03/01/23, documented Resident #1 wandered and required redirection. The interventions listed included: consider residents need to rest and prompt as appropriate, consider if resident may be hungry or thirsty and provide snacks and drinks, consider if resident may need to use the bathroom and assist as needed and direct to an appropriate wandering space. The Personal Service Plan lacked interventions for Resident #1's sexual behaviors. On 03/21/23 at 10:34 AM, a Medication Technician verbalized Resident #3 was seen holding hands with Resident #1 on 03/14/23. The Medication Technician explained this was the first-time staff had seen such an interaction between Resident #3 and Resident #1. Resident #1 had a behavior of wandering. The Resident wandered in and out of resident rooms, as well as any areas the resident could access in the facility. Due to short staffing, caregivers had to be responsible for more than one hall. Caregivers were having to cover two halls at times. Residents like to congregate in the Garden Hall. Residents who wander tend to wander to the Boat Hall. There was not a staff member assigned to Boat Hall. Staff do not really go into Boat Hall unless they are looking for a wandering resident. Resident #1 and Resident #3 reside in the Boat Hall. On 03/21/23 at 11:58 PM, the Executive Director reviewed the staffing sheets from the month of March and confirmed staffing did not meet the regulatory requirement for one caregiver to six residents. The Executive Director confirmed the facility only had four caregivers in the building from 6:00 PM until 10:05 PM on 03/14/23. On 03/21/23 at 1:05 PM, the Activities Manager verbalized the Activities Manager also filled in as a Caregiver and a Medication Technician in the facility. The Activities Manager verbalized Resident #1 wandered. On 03/14/23, Resident #3 was seen			

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	repeatedly holding hands with Resident #1 in the common areas of the facility. At times, Resident #3 was seen placing the resident's head on Resident #1's chest. The Activities Manager had not seen this behavior from Resident #3 until that day. The staff made multiple attempts to redirect Resident #3 away from Resident #1. At approximately 9:40 PM on 03/14/23, the Activities Manager received a call on the radio to go to room 42 in the Boat Hall. The Activities Manager went to room 42 and found two caregivers in the doorway of the room. Resident #1 was seated on the edge of the bed in a nude state, with the lights turned off and exhibiting signs of arousal. Meanwhile, Resident #3 was inside the bed, covered with sheets that concealed their naked body.Resident #3 was screaming at the caregivers and was very confused. Resident #3 informed the caregivers Resident #1 was Resident #3's spouse. Resident #3 and Resident #1 were separated. The Activities Manager cleaned up Resident #3, put the resident in clean briefs, and took the resident's clothing and bedding to the laundry. The Activities Manager verbalized the incident seemed consensual because Resident #3 thought Resident #1 was the resident's spouse, however, the Activities Manager confirmed Resident #3 did not know who the resident was truly consenting with. The Activities Manger verbalized the potential lack of oversight due to the facility being short staffed could have resulted in the suspected sexual abuse going as far as it did. On 03/21/23 At 3:05 PM, the Executive Director verbalized Resident #3 was not referred to behavioral health services for the onset of the new behaviors or for an assessment for psychosocial harm after the incident. The Executive Director verbalized Resident #3's physician was notified however the facility did not make an appointment for the resident to be seen by the resident's physician for a physical after the incident. On 03/21/23 At 3:07 PM, the Director of			

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	Clinical Services verbalized the facility did not refer Resident #1 or Resident #3 to behavioral health services for an assessment for psychosocial harm. The facility contacted Resident #3's physician on 03/15/23, however the facility did not request an appointment for Resident #3 to be seen for a physical after the incident. The Director of Clinical Services explained when a resident has a new onset of behaviors, the behavior should be documented on the resident Service Plan. The Director of Clinical Services confirmed no updates were made to the service plans for Resident #1 and Resident #3. Resident #3's new behavior should have been updated and Resident #1 Service Plan should have been updated with interventions for increased monitoring of the resident. Staff should have been rounding to see where Resident #1 was when not in the common areas. On 03/21/23 At 3:24 PM, the Executive Director of verbalized there was not a caregiver assigned to the Boat Hall because only four residents lived in the hall. Staff go into the Boat Hall when rounding. Residents were typically in the Garden Hall and were not in their rooms on the Boat Hall. On 03/21/23 at 3:26 PM, the Director of Clinical Services verbalized Resident #1 should be in a hallway with full staffing where the staff can monitor the resident. The Director of Clinical Services confirmed Resident #1 resided on the least staffed hall. The facility policy titled "Abuse, Neglect, and Exploitation Policy-NV-1," revised 05/2021, documented any person who was harmed during an incident should be provided with medical attention as appropriate. If an incident involves resident on resident contact, both residents should be evaluated for a change of condition. Residents exhibiting aggressive behavior should be considered for continued appropriateness and intervention should be developed to address their behaviors. The resident assessment and Service plan should be updated as appropriate. In the			

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	event of suspected rape or sexual abuse, the following procedure should also occur in addition to the procedure above: A. Develop Plan - a plan should be developed as soon as practicable and implemented to protect the suspected victim. B. Medical Examination - the suspected victim should have a medical examination as soon as possible. Prior notice should be given to the examining physician that the individual may have been raped or sexually abused. The victim and/or the Legally Responsible Party (if the resident lacks capacity) have the right to refuse this examination. C. Preserving Evidence - evidence or potential evidence (linens, clothing, and bodily fluids) should be preserved and not altered or destroyed. D. Provide Counseling - the community should contact an agency or individual trained in dealing with rape or sexual abuse to interview the resident and provide counseling for intervention as needed. Complaint #NV00068206 Severity: 3 Scope 1			
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.	0874	Please refer to the original Statement of Deficiency/Plan of Correction - Event ID ZL6B11	03/06/2023
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	0878	Resident #1 - Naproxen was received in the community on 3/6/23 @ 5:40pm. Resident #4 - Acetaminophen was received in the community on 3/22/23. Resident #6 - Calcium carbonate was also received at community. HWD and/or designee audited the medication cart to verify the availability of OTC medications for current residents. Corrective action taken as indicated.	04/30/2023

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	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 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 a medication was on-site to administer as prescribed for 3 of 6 sampled residents (Resident #1, #4 and #6). Findings include: Resident #1 Resident #1 was admitted to the facility on 11/14/22 with diagnoses including unspecified dementia, Alzheimer's disease, and anxiety. On 03/06/23 at 11:34 AM, during a review of residents' medications, Resident #1 lacked naproxen oral tablet 500 milligrams (mg). Resident #1's March 2023		Staff responsible for assistance with medications will be in-serviced on 04/25/2023 on the community's Medication & Treatments - Availability policy. HWD and/or designee will monitor medication cart weekly for then next four weeks to verify that OTC medications that are ordered are available.	

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	Medication Administration Record (MAR) and Physician's Order dated 10/04/22, documented the following: -naproxen oral tablet 500 mg, give one tablet by mouth every 12 hours as needed for pain Resident #4 Resident #4 was admitted to the facility on 01/13/23 with diagnoses including unspecified dementia, hypothyroidism, and hyperlipidemia. On 03/06/23 at 11:47 AM, during a review of residents' medications, Resident #4 lacked acetaminophen 1000 mg tablets. Physician's Order dated 02/16/23, documented the following: -acetaminophen 1000 mg, take by mouth three times a day. On 03/06/23 at 11:52 AM, the Medication Technician confirmed the facility lacked Resident #4's acetaminophen 1000 mg tablets and were not administering the medication as prescribed. Resident #6 Resident #6 was admitted to the facility on 12/15/22 with diagnoses including Alzheimer's disease, type 2 diabetes, and urinary incontinence. On 03/06/23 at 12:01 PM, during a review of residents' medications, Resident #6 lacked calcium carbonate, antacid. Resident #6's March 2023 MAR and Physician's Order dated 12/16/22, documented the following: -calcium carbonate oral tablet chewable, give two tablets by mouth every 12 hours as needed for dyspepsia related to gastroesophageal reflux disease without esophagitis. On 03/06/23 at 12:05 PM, the Medication Technician confirmed the facility lacked Resident #6's calcium carbonate chewable oral tablet. Severity: 2 Scope: 2			
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 medication, by an acceptable method of destruction, in the presence of a witness	0885	Resident #4 - medications that were not on MAR was removed on 3/21/23. The HWD or designee will audit medication carts for expired or discontinued medications. To be completed by 04/14/2023. Staff responsible for removal of discontinued or expired medications will be in-serviced on the community's Medication Cart Audit form and Medication & Treatment	04/30/2023

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	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 6 residents (Resident #4). Findings include: Resident #4 Resident #4 was admitted to the facility on 01/13/23, with diagnoses including Alzheimer's disease hypothyroidism and hyperlipidemia. A physician's order for Resident #4 dated 02/16/23, documented losartan 50 milligram (mg) take one tablet by mouth everyday and acetaminophen 1000 mg, take one tablet by mouth three times a day, and discontinue all other acetaminophen order. Discard on 02/16/23. The medications for Resident #4 included a bubble pack losartan potassium 50 mg tablet, take one tablet by mouth everyday and acetaminophen 325 mg tablet, take two tablets by mouth every six hours as needed for mild or moderate pain. The medication was not identified on Resident #4's MAR dated March 2023. A physician order dated 02/16/23, documented the losartan potassium 50 mg tablet, take one tablet by mouth everyday, and acetaminophen 325 mg tablet, take two tablest by mouth every six hours as needed for mild or moderate pain should have been discontinued. On 03/06/23 at 12:04 PM, the Medication Technician confirmed the losartan potassium and acetaminophen should have been discarded on 02/16/23. The medication should have been pulled out of the cart so the medication was not administered to the resident. Severity: 2 Scope: 1		disposal policy on 04/25/2023. To assist with ongoing compliance, HWD or designee will audit medication carts bi-weekly for 30 days to ensure there are no discontinued or expired medications on the cart.	

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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.	0905	Please refer to the original Statement of Deficiency/Plan of Correction - Event ID ZL6B11	03/06/2023
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.	0923	Please refer to the original Statement of Deficiency/Plan of Correction - Event ID ZL6B11	03/06/2023
0936 SS= E	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	0936	Resident #2 and #6 were administered first TB tests and second TB tests to be completed by 04/21/2023, Staff responsible for completion of TB tests have been in-serviced on the community's policy. An audit was completed on all resident files by 04/14/2023 and all residents TB tests are in compliance with standards. HWD or designee will monitor compliance on a regular basis. HWD or designee will monitor compliance on newly admitted residents and ensure	04/21/2023

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	the regulations adopted pursuant thereto. Inspector Comments: Based on record review and interview, the Administrator failed to ensure tuberculosis (TB) testing records were complete, including the time given and/or time results read and second step tests for 2 of 6 sampled residents (Resident #2 and #6). Findings include: Resident #2 Resident #2 was admitted to the facility on 10/23/22 with a diagnoses of Alzheimer's disease. Resident #2's file documented a 1-step TB test administered on 08/24/22 and read negative on 08/26/22. The resident's file lacked documented evidence of a second step TB test and times given and the times read. On 03/06/23 at 10:30 AM, the Executive Director verbalized Resident #2 should have been administered a second step TB test and confirmed the TB record lacked the time given and the time read. Resident #6 Resident #6 was admitted to the facility on 12/15/22, with diagnoses including Alzheimer's disease, type 2 diabetes and urinary incontinence. Resident #6's clinical record documented an admission first step TB test given on 12/15/22 and read negative on 12/18/22 and second step TB test given on 12/22/22 and read negative on 12/25/22. Resident #6's TB testing lacked evidence of the times given and the times read. On 03/06/23 at 10:32 AM, the Administrator confirmed the TB records for Resident #6 lacked the time given and the time read and the standard of practice of reading the TB test between 48 and 72 hours could not be confirmed without times. Severity: 2 Scope: 2		complete TB surveillance and testing yearly for residents that require it.	
0966 SS= F	Alzheimer’s Care - NAC 449.2754 Residential facility which provides care to persons with Alzheimer ' s disease: Application for endorsement; general requirements. (NRS 449.0302) 5. The administrator of such a facility shall prescribe and maintain on the premises of the facility a written statement which includes: (b) Evidence that the facility has	0966	Staffing schedule has been updated to reflect that interaction groups with residents contain no more than six residents per caregiver during waking hours. Staff responsible for scheduling have been in-serviced on the community's Staffing Requirements Policy and applicable regulatory requirements, including the need	03/21/2023

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	established interaction groups within the facility which consist of not more than six residents for each caregiver during those hours when the residents are awake; Inspector Comments: Based on interview and document review, the facility failed to ensure there was staffing of one Caregiver for every six residents during residents' waking hours in an Alzheimer's endorsed facility. Findings include: On 03/21/23 at 11:04 PM, the Executive Director verbalized the required ratio for memory care was one caregiver to six residents. Review of the March 2023 staffing schedule documented the following dates and times the facility was not providing one caregiver to six residents who resided in the facility which was endorsed for Alzheimer's Disease. The census for March 2023 was 31 or more each day of the month, requiring 6 staff members during resident waking hours. Staffing was not met on the following dates during the noted hours: - 03/01/23 between the hours of 6:00 AM to 10:00 AM - 03/02/23 between the hours of 6:00 AM to 10:00 AM - 03/03/23 between the hours of 6:00 AM to 10:00 AM, and 2:00 PM to 4:00 PM - 03/04/23 between the hours of 6:00 AM to 10:00 AM, and 2:00 PM to 4:00 PM - 03/05/23 between the hours of 2:00 PM to 10:05 PM - 03/06/23 between the hours of 2:00 PM to 10:05 PM - 03/07/23 between the hours of 2:00 PM to 4:30 PM, and 6:00 PM to 10:05 PM - 03/08/23 between the hours of 2:00 PM to 4:30 PM - 03/09/23 between the hours of 2:00 PM to 4:30 PM - 03/10/23 between the hours of 2:00 PM to 4:30 PM - 03/11/23 between the hours of 6:00 AM to 7:00 AM, and 2:00 PM to 4:00 PM - 03/12/23 between the hours of 2:00 PM to 10:05 PM - 03/13/23 between the hours of 2:00 PM to 10:05 PM - 03/14/23 between the hours of 6:00 PM to 10:05 PM - 03/15/23 between the hours of 2:00 PM to 4:30 PM - 03/16/23 between the hours of 2:00 PM to 4:30 PM - 03/17/23 between the hours of 4:30 PM to 10:05 PM - 03/18/23		to maintain evidence that interaction groups with residents contain no more than six residents per caregiver. Administrator or designee will verify that staffing in community meets appropriate levels by reviewing schedules daily, weekly and monthly to adjust schedule to resident needs.	

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	between the hours of 6:00 AM to 7:00 AM, and 2:00 PM to 4:00 PM - 03/19/23 between the hours of 6:00 AM to 2:15 PM, and 2:00 PM to 10:05 PM - 03/20/23 between the hours of 6:00 AM to 2:15 PM, and 2:00 PM to 4:30 PM, and 6:00 PM to 10:05 PM On 03/21/23 at 11:58 AM, the Executive Director reviewed the staffing sheets from March 2023 and confirmed staffing did not meet the regulatory requirement of one caregiver to six residents. On 03/21/23 at 3:07 PM, the Director of Clinical Services verbalized the facility considered waking hours to be between 6:00 AM and 9:00 PM. The facility policy titled "Staffing Requirements Policy NV-6," dated 03/2023, documented sufficient personnel would be scheduled to meet resident needs. Each caregiver should have no more than 6 residents assigned to them when the residents were awake. Complaint #NV00068206 Severity: 2 Scope: 3			

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0994 SS= D	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 in 5 of 32 resident rooms. Findings include: On 03/06/23 between 10:02 AM and 11:05 AM, the following dangerous items were observed in resident rooms: Room 28 - 19 push pins held pictures on the walls. Room 34 - a push pin held a calendar on the wall. Room 27 - a lighter was in the drawer of the resident's nightstand. Room 36 - a five-pack of disposable shaving razors were in the unlocked bathroom cabinet. Room 40 - a pair of scissors On 03/06/23 at each discovery, the Maintenance Manager confirmed the dangerous items were unsecured in resident rooms and verbalized all of the items should have been secured from the residents to keep the residents safe. Severity: 2 Scope: 1	0994	All items cited were removed and/or secured on 3/21/23. An inspection of all resident rooms by 4/14/23 to ensure no dangerous items are available. To assist with compliance, ED or designee will conduct a random room audit weekly for the next 30 days and retrain staff as appropriate.	04/30/2023
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	0999	All toxic items or substances cited were removed and/or secured on 3/21/23. An inspection of all resident rooms completed by 4/14/23 to ensure no dangerous items are available to residents. Staff will be in-serviced on the Sweep and Secure Hazardous Items memo on 04/25/2023. To assist with compliance, Ed or designee	04/30/2023

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	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 in 15 of 32 resident rooms. Findings include: On 03/06/23 between 10:02 AM and 11:05 AM, the following toxic substances were observed in resident rooms: Room 5 - an eight-ounce container of Young Living hand and body lotion and 15 0.5-ounce bottles of Young Living essential oils. Room 11 - an eight-ounce container of Remedy cleanser no-rinse spray. Room 13 - a 5.4-ounce tube of Crest with Scope adult toothpaste. Room 26 - a 2.4-ounce tube of Crest adult toothpaste. Room 25 - an eight-ounce container of Skintegrity wound cleanser spray. Room 30 - a 15-ounce container of Suave men's hydrating 3-in1 hair, body, and face. Room 31 - a three-ounce container of Trader Joe's rose oil ultra-moisturizer hand cream. Room 30 - a 15-ounce container of Suave men's hydrating 3-in1 hair, body, and face. Room 31 - a 5.2-ounce tube of Crest 3-D white adult toothpaste; a 7.5-ounce container of Dial antibacterial liquid soap; a four-ounce container of Remedy essentials; a 1.5-ounce container of moist and mint conditioner; a 23.6-ounce container of Pantene 2-in-1 shampoo/conditioner; a 30-ounce container of Olay ultra-moisture body wash; a 2.8-ounce container of Secret deodorant; a two-ounce container of Top Care shampoo. Room 40 - a container of disinfecting wipes; a 15-ounce container of Suave exfoliating body wash; a four-ounce tube of Colgate sparkling white adult toothpaste; a 2-ounce tube of Fixodent denture adhesive; a two-ounce container of Speed Stick deodorant; and an 8.5-ounce bottle of Listerine mouthwash. Room 35 - an eight-ounce container of Ensure. Room 36 - a 12-ounce can of shave foam. Room 27 - an 8.5-ounce container of Tena ProSkin cleansing cream. Room 43 - a 13.5-ounce container of Herbal Essence white grapefruit and mint body wash. Room 45 - a		will conduct a random room audit weekly for the next month and retrain staff as appropriate.	

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	31-ounce container of Dove Men 2-in-1 shampoo and conditioner; a 33.8-ounce container of Tena body wash and shampoo; glass cleaner wipes; six 3.4-ounce containers of ProSkin barrier cream; and a four-ounce tube of AP24 whitening fluoride toothpaste. On 03/06/23, the Maintenance Manager was present at each discovery and verbalized the items should not be stored unsecured in resident rooms. Severity: 2 Scope: 2			