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 _____	**05/15/2024**

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 grading resurvey and complaint investigation conducted at your facility on 05/15/2024. 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, with assisted living services for elderly or disabled persons, and/or persons with Alzheimer's disease, Category II residents. The census at the time of the survey was 32. Six resident files were reviewed, and three closed records were reviewed. Seven employee files were reviewed. One complaint was investigated. The facility received a grade of D. 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. Complaint #NV00070154 with the following allegations were substantiated. Allegation #1: Medications were not secured to all residents in the facility (See tag Y0920). Allegation #2: Medications were not being administered as prescribed (See tag Y0895). Allegation #3: The facility did not have enough staff at all times (See tag Y0966). The following allegations could not be substantiated due to a lack of evidence. Allegation #4: Environment - Resident's room smells of urine, and bed linens soiled.	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | Name: SAMUEL GARCIA-FELIX | Title: Executive Director | Date: 06/28/2024

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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	Allegation #5: Meals were not provided if missed. Allegation #6: Resident's clothing was missing and replaced with clothes too small for the resident. Allegation #7: Resident was not provided with daily hygiene. Allegation #8: Lack of communication with family. Allegation #9: Resident-to-Resident Abuse. Allegation #10: Resident had multiple falls due to staff not ensuring the resident used a walker. Investigation into the allegations included: Observation of cleanliness in resident rooms, dining room, activity room, lounges, the facility grounds, exits including door handles, and staff-to-resident interactions. Interviews were conducted with three residents, a Caregiver, a Medication Technician, the Wellness Director, and the Executive Director. Record review included face sheets with diagnoses, physician orders, and Medication Administration Records (MARs) for nine residents. Document review included the following: -List of residents discharged from the facility during the previous six months -Daily Census reports and list of active residents for the previous three months -Staffing Schedules for the previous six months -Medication & Treatment Storage Policy -Resident Rights -Medication Administration -Grievance Policy -Food and Mealtime Preference Policy -Shift to Shift "Hand-Off" Communication Report Policy -Abuse, Neglect and Exploitation Reporting -Medication and Treatment - Refusal Policy -Activities of Daily Living (ADL) Care Documentation Policy 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:			

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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, clinical record review, document review, and interview, the Administrator failed to provide oversight and direction for the employees to provide the necessary needed services and protective supervision to residents. Findings include: Please see TAG Y0074, Y0102, Y0104, Y0450, Y0878, Y0895, Y0920, Y0966, Y0994, Y0999, and Y1540. Severity: 2 Scope: 3	0050	The following is the Plan ofCorrection for Brookdale Reno regarding the State Licensure gradingResurvey and complaint investigation conducted 5/15/2024**.** ThisPlan of Correction is not to be construed as an admission of or agreement withthe findings and conclusions in the resurvey or any related sanction orfine. Rather, it is a submitted as confirmation of our ongoing efforts tocomply with statutory and regulatory requirements. In this document, wehave outlined specific actions in response to identified issues. We havenot provided a detailed response to each allegation or finding, nor have weidentified mitigating factors. We remain committed to the delivery ofquality health care services and will continue to make changes and improvementto satisfy that objective. 1) Current and acting administrators will provide oversight and direction for the employees to provide the necessary needed services and protective supervision to residents. 2) Plan of Corrections detailed for each Tag listed in the Statement of Deficiency will be put into place to correct the deficient practice. 3) Monitoring of corrective actions will be done by methods listed in each individual plan of correction. 4) Administrator and Executive Director will be responsible to verify each plan of correction is implemented. 5) Corrective actions will be completed as listed in each separate corrective action. 6) Attached are documents listed from each plan of correction.	06/28/2024
0074 SS= D	Elder Abuse Training - NRS 449.093 Training to recognize and prevent abuse of older persons: Persons required to receive; frequency; topics; costs; actions for failure to complete. 1. An applicant for a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide	0074	1) Associates are currently trained on Elder Abuse and all future new hires will be trained on Elder Abuse prior to resident contact. 2) Using the Resident Assistant Orientation Checklist to track their progress, new hires will undergo required training, namely, Elder	06/25/2024

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	personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before a license to operate such a facility, agency or home is issued to the applicant. If an applicant has completed such training within the year preceding the date of the application for a license and the application includes evidence of the training, the applicant shall be deemed to have complied with the requirements of this subsection. 2. A licensee who holds a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must annually receive training to recognize and prevent the abuse of older persons before the license to operate such a facility, agency or home may be renewed. 3. If an applicant or licensee who is required by this section to obtain training is not a natural person, the person in charge of the facility, agency or home must receive the training required by this section. 4. An administrator or other person in charge of a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before the facility, agency or home provides care to a person and annually thereafter. 5. An employee who will provide care to a person in a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before the employee provides care		Abuse in the first 7 days of their orientation and training schedule and agenda (agenda is also sent to new hires). The Checklist will be signed by an assigned trainer and dated when completed. This Checklist will be required to be completed prior to resident contact. 4) This corrective action will be monitored for completion using the Resident Assistant Orientation Checklist which will be attached to the employee file. In addition, the progress of trainings for staff to indicate completion of trainings and due dates of when trainings will need to be renewed will be documented and updated as the new hire completes trainings. This will be reviewed at least once a month to ensure employees needing to renew training receive it before their due dates. 4) The Business Office Coordinator will be responsible for monitoring the progress of the new employee training and orientation schedule. The Executive Director will confirm that completion of required trainings are completed prior to resident contact. 5) Corrective action including Orientation Checklist and documentation was implemented on 6/25/24. 6) See attached supporting documentation.	

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	to a person in the facility, agency or home and annually thereafter. 6. The topics of instruction that must be included in the training required by this section must include, without limitation: (a) Recognizing the abuse of older persons, including sexual abuse and violations of NRS 200.5091 to 200.50995, inclusive; (b) Responding to reports of the alleged abuse of older persons, including sexual abuse and violations of NRS 200.5091 to 200.50995, inclusive; and (c) Instruction concerning the federal, state and local laws, and any changes to those laws, relating to: (1) The abuse of older persons; and (2) Facilities for intermediate care, facilities for skilled nursing, agencies to provide personal care services in the home, facilities for the care of adults during the day, residential facilities for groups or homes for individual residential care, as applicable for the person receiving the training. 7. The facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care is responsible for the costs related to the training required by this section. 8. The administrator of a facility for intermediate care, facility for skilled nursing or residential facility for groups who is licensed pursuant to chapter 654 of NRS shall ensure that each employee of the facility who provides care to residents has obtained the training required by this section. If an administrator or employee of a facility or home does not obtain the training required by this section, the Division shall notify the Board of Examiners for Long-Term Care Administrators that the administrator is in violation of this section. 9. The holder of a license to operate a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care shall ensure that			

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	each person who is required to comply with the requirements for training pursuant to this section complies with such requirements. The Division may, for any violation of this section, take disciplinary action against a facility, agency or home pursuant to NRS 449.160 and 449.163. Inspector Comments: Based on personnel file review and interview, the Administrator failed to ensure 1 of 7 sampled employees received initial elder abuse training prior to beginning work at the facility (Employee #2). Findings include: On 05/15/2024, the Business Office Coordinator was provided the Personnel Check List to complete for 10 sampled employees. On 05/15/2024, the Business Office Manager provided the completed form with the following information: Employee #2 Employee #2 was hired by the facility as Executive Director with a start date of 12/01/2023. Employee #2's personnel file contained an elder abuse training certificate dated 12/11/2023, after beginning work at the facility. On 05/15/2024, the Executive Director provided the Attestation of Compliance form, signed and dated 05/15/2024, confirming the Business Office Manager had conducted a thorough review of the personnel records to determine compliance and any noncompliance found. The Executive Director verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. Severity: 2 Scope: 1			
0088 SS= C	Staffing Schedule - NAC 449.199 Staffing requirements 4. The administrator of a residential facility shall maintain monthly a written schedule that includes the number and type of members of the staff of the facility assigned for each shift. The schedule must be amended if any changes are made to the schedule. The schedule must be retained for at least 6 months after the schedule expires.	0088	Please refer to original Statement of Deficiency/Plan of Correction - Event ID 8V4711.	05/15/2024

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0100 SS= D	Personnel File - NAC 449.200 & R043-22 Personnel files. (NRS 449.0302) 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (a) The name, address, telephone number and social security number of the employee; (b) The date on which the employee began his or her employment at the residential facility; (c) Records relating to the training received by the employee, including, without limitation: (1) Certificates of completion for all training completed by the employee; and (2) If a tier 2 training is not provided through a course listed on the Internet website maintained by the Division pursuant to subsection 2 of section 7 of this regulation, a list of topics covered by the training which may consist of, without limitation, the syllabus for the training or an outline of the training; (e) Evidence that the references supplied by the employee were checked by the residential facility.	0100	Please refer to original Statement of Deficiency/Plan of Correction - Event ID 8V4711.	05/15/2024

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0102 SS= D	Personnel File - TB Screening - NAC 449.200 Personnel files. 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (d) The health certificates required pursuant to chapter 441A of NAC for the employee; Inspector Comments: Based on record review, document review, and interview, the facility failed to ensure employees met the requirements concerning tuberculosis (TB) testing and pre-employment physical for 1 of 7 sampled employees (Employee #1). Findings include: On 05/15/2024, the Business Office Coordinator was provided the Personnel Check List to complete for 10 sampled employees. On 05/15/2024, the Business Office Manager provided the completed form with the following information: Employee #1 Employee #1 was employed as Administrator on 04/02/2024. Employee #1's personnel file contained a physical dated 05/03/2024, after beginning work at the facility. On 05/15/2024, the Executive Director provided the Attestation of Compliance form, signed and dated 05/15/2024, confirming the Business Office Manager had conducted a thorough review of the personnel records to determine compliance and any noncompliance found. The Executive Director verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. Severity: 2 Scope: 1	0102	1) To correct finding, any physical examination that is due or missing for staff will be identified and staff will be required to receive examination before continuing employment as outlined in New Hire Checklist. 2) Physical exams for employees will be recorded and tracked. Documentation of physical exams will be kept in appropriate employee file. New Hires will follow the New Hire Checklist in order to complete appropriate hiring steps are done prior to resident contact and completed in required time lines. 3) Monitoring of this action will be done by the Executive Director or designee. 4) The Business Office Coordinator and Executive Director will be responsible to implement the plan of correction. Both Business Office Coordinator and Executive Director will verify that New Hire Checklist is complete and supporting documentation is present. 5) Corrective action has been implemented on 6/25/24. 6) Attached is supporting documentation	06/26/2024

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0104 SS= D	Personnel Files - Background Checks - NAC 449.200 Personnel files. (NRS 449.0302) 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (f) Evidence of compliance with NRS 449.122 to 449.125, inclusive. Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 7 sampled employees met background check requirements (Employee #1). Findings include: On 05/15/2024, the Business Office Coordinator was provided the Personnel Check List to complete for 10 sampled employees. On 05/15/2024, the Business Office Manager provided the completed form with the following information: Employee #1 Employee #1 was employed as Administrator on 04/02/2024. Employee #1's personnel file lacked documented evidence of a background check. On 05/15/2024, the Executive Director provided the Attestation of Compliance form, signed and dated 05/15/2024, confirming the Business Office Manager had conducted a thorough review of the personnel records to determine compliance and any noncompliance found. The Executive Director verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. Severity: 2 Scope: 1	0104	1) To correct findings, employee missing background check has been sent to take background checks. Future hires will receive background check during pre-employment phase of hiring. 2) Background checks for new employees will be recorded and tracked. Results of background check will be kept in appropriate employee file. New Hires will follow the New Hire Checklist to complete appropriate hiring steps prior to their first day of employment. 4) The Business Office Coordinator and Executive Director will be responsible for implementing the plan of correction. Both Business Office Coordinator and Executive Director will verify that New Hire Checklist is complete and supporting documentation is present. 5) Corrective action has been implemented on 6/25/24. 6) 6) Attached is the supporting documentation.	06/25/2024
0174 SS= D	Health& Sanitation-odors-hazards-insects-dirt - NAC 449.209 Health and sanitation. (NRS 449.0302) 4. To the extent practicable, the premises of the facility must be kept free from: (a) Offensive odors; (b) Hazards, including obstacles that impede the free movement of residents within and outside the facility; (c) Insects and rodents; and (d) Accumulations of dirt, garbage and other refuse.	0174	Please refer to original Statement of Deficiency/Plan of Correction - Event ID 8V4711.	05/15/2024

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0178 SS= D	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.	0178	Please refer to original Statement of Deficiency/Plan of Correction - Event ID 8V4711.	05/15/2024
0250 SS= D	Kitchens- Equipment Works; Clean And Sanitary - NAC 449.217 Kitchens; storage of food; adequate supplies of food; permits; inspections. (NRS 449.0302) 1. The equipment in a kitchen of a residential facility and the size of the kitchen must be adequate for the number of residents in the facility. The kitchen and the equipment must be clean and must allow for the sanitary preparation of food. The equipment must be in good working condition.	0250	Please refer to original Statement of Deficiency/Plan of Correction - Event ID 8V4711.	05/15/2024
0252 SS= D	Storage of Food - Adequate Storage; Packaging - NAC 449.217 Kitchens; storage of food; adequate supplies of food; permits; inspections. (NRS 449.0302) 3. Sufficient storage must be available for all food and equipment used for cooking and storing food. Food that is stored must be appropriately packaged.	0252	Please refer to original Statement of Deficiency/Plan of Correction - Event ID 8V4711.	05/15/2024
0272 SS= C	Service of Food - Menus - NAC 449.2175 3. Menus must be in writing, planned a week in advance, dated, posted and kept on file for 90 days.	0272	Please refer to original Statement of Deficiency/Plan of Correction - Event ID 8V4711.	05/15/2024

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0450 SS= D	First Aid & CPR - NAC 449.231 First aid and cardiopulmonary resuscitation. (NRS 449.0302) 1. Within 30 days after an administrator or caregiver of a residential facility is employed at the facility, the administrator or caregiver must be trained in first aid and cardiopulmonary resuscitation. The advanced certificate in first aid and adult cardiopulmonary resuscitation issued by the American Red Cross or an equivalent certification will be accepted as proof of that training. Inspector Comments: Based on interview and record review, the facility failed to ensure 1 of 7 sampled employees (Employee #2) had completed cardiopulmonary resuscitation (CPR) and first aid training within 30 days of employment. Findings include: On 05/15/2024, the Business Office Coordinator was provided the Personnel Check List to complete for 10 sampled employees. On 05/15/2024, the Business Office Manager provided the completed form with the following information: Employee #2 Employee #2 was hired by the facility as Executive Director with a start date of 12/01/2023. Employee #2's personnel file contained CPR and first aid training certificate dated 01/17/2024, greater than the required 30 days. Severity: 2 Scope: 1	0450	1) Current staff have received CPR and new hires have received CPR within 30 days of hire date. 2) A checklist will be used to track the progress of required training, namely, CPR. 4) The Business Office Coordinator and Executive Director will implement by scheduling CPR classes for new hires. CPR certification will be kept in the employee file as soon as it is received. 5) This corrective action has been implemented on 6/25/25. 6) See attached supporting documentation	06/25/2024
0590 SS= F	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 administrator of a residential facility shall ensure that: (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;	0590	Please refer to original Statement of Deficiency/Plan of Correction - Event ID 8V4711.	05/15/2024

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 _____	**05/15/2024**

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

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0859 SS= D	Medical Care of Resident After Illness - NAC 449.274 and R043-22 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 a qualified provider of health care in accordance with NRS 449.1845. The resident must be cared for pursuant to any instructions provided by the qualified provider of health care.	0859	Please refer to original Statement of Deficiency/Plan of Correction - Event ID 8V4711.	05/15/2024
0878 SS= F	Medication/OTCS, Supplements, Change Order - NAC 449.2742 and R043-22 - 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 , physician assistant or advanced practice registered nurse has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician, physician assistant or advanced practice registered nurse. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician, physician assistant or advanced practice registered nurse. The administration of over-the-counter medications and dietary supplements must be included in the record required pursuant to paragraph (b) of subsection 1 of NAC 449.2744. 6. Except as otherwise provided in this subsection, a medication prescribed by a physician, physician assistant or advanced practice registered nurse must be administered as prescribed by the physician, physician assistant or advanced practice registered nurse. If a physician, physician assistant or advanced practice registered nurse orders	0878	1) Regular monitoring and audits of medications will be implemented to identify when medications need to be reordered at 10 days before supplies and to identify changes to orders and updates that need to be recorded. Medication Technicians (MT) will be re-educated how to reorder medications, and identification of any order changes and labels that need to be placed or corrected will be performed. 2) Medication technicians (MT) will be trained on the procedure to reorder medications and communicate with pharmacy and/or Resident responsible party. Regular audits of MAR and medication inventory will take place at the end of the shift. Additionally, monthly audits by HWD or designee will be performed to ensure that audits by the Med Technicians are sufficient and serve as a secondary level of monitoring. 3) Medication technicians will monitor medication passes in the last 24 hours with status of medication passes. 4) The Health and Wellness Director and Executive Director will be responsible to implement this plan of correction by dating and signing the monthly audit reports to confirm audit was completed. 5) Medication Technician training has been completed on 6/26/24 and included policy	06/26/2024

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	a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order; (2) Indicate on the container of the medication that a change has occurred; and (3) Note the change in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; (b) Within 5 days after the change is ordered, a copy of the order or prescription signed by the physician, physician assistant or advanced practice registered nurse must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; and (c) If the label prepared by a pharmacist does not match the order or prescription written by a physician, physician assistant or advanced practice registered nurse, a physician, registered nurse or pharmacist must interpret that order or prescription and, within 5 days after the change is ordered, the interpretation must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744. Inspector Comments: Based on observation, document review, record review, and interview, the facility failed to ensure 1) medications were onsite and available as prescribed for 4 of 6 sampled residents (Resident #2, #3, #4, and #6), and 2) medications had a change label for a change in the physician's order for 1 of 6 sampled residents (Resident #6). Findings include: Resident #2 was admitted to the facility on 02/02/2024, with diagnoses including Alzheimer's disease, essential hypertension, type II diabetes mellitus and protein-calorie malnutrition. Resident #2's May 2024 Medication Administration Record (MAR) and physician's order documented the following medications were not onsite during the resident's medication review: - bisacodyl rectal suppository 10 milligrams (mg), insert one applicator rectally every 24 hours as needed for		on medication storage, passing, documentation, refilling medication and communicating with pharmacy and resident responsible party. 6) See attached documentation.	

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	constipation. Only give if milk of magnesia was ineffective. - fleet enema rectal enema 7-19 mg/118 milliliters (ml) (sodium phosphates), insert one applicator full rectally every 24 hours as needed for constipation. Give daily if no result from bisacodyl supplement within 24 hours. On 05/15/2024 at 2:50 PM, the Medication Technician (MT) confirmed Resident #2's bisacodyl and fleet enema medications were not onsite. Resident #3 Resident #3 was admitted to the facility on 04/23/2024, with diagnoses including Alzheimer's disease, epilepsy, and hemiplegia and hemiparesis following cerebral infarction of the dominant left side. Resident #3's May 2024 MAR and physician's order documented the following medication was not onsite during the resident's medication review: - milk of magnesia oral suspension 1200 mg/15 ml, give 30 ml by mouth every 24 hours as needed if no bowel movement for three days. On 05/15/2024 at 2:32 PM, the MT confirmed Resident #3's milk of magnesia medication was not onsite. Resident #4 Resident #4 was admitted to the facility on 04/29/2024, with diagnoses including unspecified dementia without behavioral disturbances, diabetes mellitus, essential hypertension, and age-related osteoporosis. Resident #4's May 2024 MAR and physician's order documented the following medication was not onsite during the resident's medication review: - rosuvastatin calcium 5 mg, give one tablet by mouth at bedtime related to essential hypertension. On 05/15/2024 at 2:20 PM, the MT confirmed Resident #4's rosuvastatin medication was not onsite. Resident #6 Resident #6 was admitted to the facility on 04/15/2024, with diagnoses including unspecified dementia, major depressive disorder, anxiety, and essential hypertension. Resident #6's May 2024 MAR and physician's order documented the following medication was not onsite during the resident's medication review: - vitamin D3 50 micrograms (mcg), give pone			

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	capsule by mouth in the morning. On 05/15/2024 at 2:11 PM, the MT confirmed Resident #6's vitamin D3 medication was not onsite. Resident #6's May 2024 MAR and physician's order documented the following medications did not match the label on the medication container: - albuterol sulfate HFA inhalation aerosol solution 108 mcg/ACT, inhale 2 puffs orally every four hours as needed for shortness of breath. The medication container documented inhale one puff every four hours as needed for shortness of breath. - lactulose oral solution 10 grams (gm)/15 ml, give 30 ml by mouth every 12 hours as needed for constipation. The medication container documented take 30 ml by mouth three times a day. - ondansetron HCL 4 mg, give one tablet by mouth every 12 hours as needed for nausea. The medication container documented one tablet by mouth everyday at 2:00 PM. On 05/15/2024 at 2:04 PM, the Health and Wellness Director (HWD) confirmed the medication container labeling for Resident #6's albuterol, lactulose and ondansetron did not match the current orders and confirmed the medication containers required a change sticker. On 05/15/2024 at 4:30 PM, the HWD verbalized the MT should fax an order for a resident's medication refill when the remaining supply reaches seven days. The facility policy titled "Order Medications," last revised March 2019, documented to provide guidance to associates placing orders for resident medications. When a resident's medication supply reaches seven days, fax a refill request to the pharmacy. The facility policy titled "Medication & Treatment - Storage, Handling, Distribution, and Payment," last reviewed 03/32/2022, documented the medication label should be consistent with a physician/healthcare provider order and with applicable regulatory requirements. This was a repeat deficiency from the State annual survey on 09/21/2023. Severity: 2 Scope: 3			
0895	Administration of Medication Maintenance -	0895	1) Medication Technicians (MT) will be	06/26/202

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SS= F	NAC 449.2744 and R043-22 Administration of medication: Maintenance and contents of logs and records. (NRS 449.0302) 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall maintain: (b) A record of the medication administered to each resident. The record must include: (1) The type of medication administered; (2) The date and time that the medication was administered; (3) The date and time that a resident refuses, or otherwise misses, an administration of medication; (4) Instructions for administering the medication to the resident that reflect each current order or prescription of the resident's physician, physician assistant or advanced practice registered nurse, including, without limitation, whether the medication is to be administered according to a routine schedule or as needed; (5) Any change in an order or prescription of a resident ' s physician, physician assistant or advanced practice registered nurse,including, without limitation, the discontinuation of the medication; (6) Any time when the resident is out of the facility; and (7) Any mistakes made in the administration of medication. Inspector Comments: Based on record review, document review and interview, the facility failed to ensure the Medication Administration Record (MAR) was accurate for 4 of 9 sampled residents (Resident #2, #4, #6 and #7). Finding include: Resident #2 Resident #2 was admitted to the facility on 02/02/2024, with diagnoses including Alzheimer's disease, essential hypertension, type II diabetes mellitus and protein-calorie malnutrition. Resident #2's May 2024 MAR lacked documented evidence the following medications were administered on 05/10/2024: - Rivastigmine tartrate 6 milligrams (mg), give one capsule by mouth at bedtime for dementia. - Simvastatin 20 mg, give one tablet by mouth at bedtime for lipids. - paroxetine		retrained on medication passes and documentation of medication passes. Medication administration will be monitored and audited. 2) Medication technicians (MT) will be retrained on the medication administration and expectations. For the next 30 days, audits of Medication Administration Record will occur at the end of each shift by shift leads. Audits will include looking for missed medication passes, missing medications, pharmacy follow up, and matching orders between MAR and medication labels. Health and Wellness Director will run daily report of medication passes. Additionally, monthly audits will be performed to verify that daily audits are sufficient and serve as a secondary level of monitoring. 4) The Health and Wellness Director and Executive Director will be responsible to implement this plan of correction by dating and signing the monthly audit reports to confirm audit was completed. 5) Medication Technician training has been completed on 6/26/24 and included policy on medication storage, passing and documentation. 6) See attached supporting documentation.	4

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	HCL 20 mg, give one tablet by mouth at bedtime for depression. - quetiapine fumarate 25 mg, give one tablet by mouth at bedtime for behaviors. - ascorbic acid 500 mg, give two tablets by mouth at bedtime for protein-calorie malnutrition. - melatonin 5 mg, give one tablet by mouth at bedtime for sleep. Resident #4 was admitted to the facility on 04/29/2024, with diagnoses including unspecified dementia without behavioral disturbances, diabetes mellitus, essential hypertension, and age-related osteoporosis. Resident #4's May 2024 MAR lacked documented evidence the following medications were administered on 05/10/2024: - rosuvastatin calcium 5 mg, give one tablet by mouth at bedtime related to essential hypertension. - senna-plus 8.6-50 mg (sennosides-docusate sodium), give one tablet by mouth at bedtime related to unspecified dementia. Resident #6 was admitted to the facility on 04/15/2024, with diagnoses including unspecified dementia, major depressive disorder, anxiety, and essential hypertension. Resident #6's May 2024 MAR lacked documented evidence the following medications were administered on 05/07/2024: - deep sea nasal spray, one spray both nostrils four times a day related to unspecified dementia. - DOK 100 mg, give one tablet by mouth two times a day related to secondary Parkinson's disease. - mirtazapine 45 mg, give one tablet by mouth at bedtime related to unspecified insomnia. - metoprolol tetrate 25 mg, give 0.5 tablet by mouth two times a day related to essential hypertension. - omeprazole delayed release 20 mg, give one tablet by mouth two times a day related to gastro-esophageal reflux disease. - sodium chloride 1 gm, give one tablet by mouth two times a day related to vitamin D deficiency. Resident #6's May 2024 MAR lacked documented evidence the following medications were administered on 05/07/2024 and 05/10/2024: - melatonin 10 mg, give one capsule by mouth at bedtime related to insomnia. - duloxetine HCL			

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	delayed release 60 mg, give two capsules by mouth at bedtime related to major depressive disorder. - carbidopa-levadopa 25-100 mg, give two tablets by mouth at bedtime related to unspecified dementia. On 05/15/2024 at 4:30 PM, the Health and Wellness Director (HWD) confirmed the missing documentation on the May 2024 MARs for Resident #2, #4 and #6. The HWD verbalized the Medication Technician's were required to document the administration of all medications to residents or to document any and all exceptions, including refusals from residents. Resident #7 Resident #7 was admitted to the facility on 10/31/2023, with diagnoses including Alzheimer's, unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. Resident #7 discharged on 12/18/2023. Resident #7's November 2023 MAR lacked documented evidence the following medications were administered per the physician's order on 11/16, 11/20 and 11/30: - Memantine HCl 10 mg tablet, give one table by mouth two times a day related to unspecified dementia. - Combigan ophthalmic solution 0.2-0.5%, instill one drop in both eyes two times a day related to glaucoma. - Donepezil HCl 5 mg oral tablet, give one tablet by mouth at bedtime related to unspecified dementia. - Latanoprost ophthalmic Solution 0.005%, instill one drop in both eyes at bedtime related to glaucoma. - Quetiapine Fumarate 25 mg tablet, give one tablet by mouth at bedtime for anxiety with evidence of restlessness, verbal/physical aggression related to Alzheimer's disease. On 05/15/2024 at 1:54 PM, the HWD confirmed the November MARs indicates Resident #7 did not receive all physician prescribed medications on 11/16/2023, 11/20/2023, and 11/30/2023. The HWD explained not giving the resident the medication as prescribed would not be following physician orders. This was a repeat deficiency from the State annual			

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	survey on 09/21/2023. Severity: 2 Scope: 3 Complaint #NV00070154			
0920 SS= F	Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 1. Medication, including, without limitation, any over-the-counter medication, stored at a residential facility must be stored in a locked area that is cool and dry. The caregivers employed by the facility shall ensure that any medication or medical or diagnostic equipment that may be misused or appropriated by a resident or any other unauthorized person is protected. Medications for external use only must be kept in a locked area separate from other medications. A resident who is capable of administering medication to himself or herself without supervision may keep the resident ' s medication in his or her room if the medication is kept in a locked container for which the facility has been provided a key. 2. Medication stored in a refrigerator, including, without limitation, any over-the-counter medication, must be kept in a locked box unless the refrigerator is locked or is located in a locked room. Inspector Comments: Based on observation and interview, the facility failed to ensure medications on 1 of 3 medication carts were secured potentially affecting all 32 residents. Findings include: On 0515/2024 at 8:35 AM, 1 of 3 medication carts sitting in the hallway outside of the Wellness Office was unlocked and the Medication Technician was not in sight of the cart. On 05/15/2024 at 8:38 AM, the Medication Technician confirmed the medications were unsecured in the medication cart and accessible to all residents. The Medication Technician verbalized all medications needed to be locked at all times to ensure residents do not access the medications. On 05/15/2024 at 10:18 AM, the Health and Wellness Director confirmed the medication carts were required to be locked when not in use or not attended to. The facility policy	0920	1) Medication Technicians (MT) will be retrained on the proper method of storing medications. 2) Medication technicians (MT) will check proper storage of medications at beginning and end of their shifts with another Medication Technician who is beginning their shift. Random checks on storage of medications will be performed to verify that medication is securely and appropriately stored. This will be done by Health and Wellness Director, Executive Director or other member of the leadership team during morning and afternoon shifts. Lead care associate will perform random checks on storage of medications during night shift. 4) The Health and Wellness Director and Executive Director will be responsible for implementing this plan of correction. 5) Medication Technician training has been completed on 6/26/24 and included policy on medication storage, passing and documentation. Random checks on medication storage will commence 6/28/24. 6) See attached supporting documentation.	06/27/2024

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	titled "Medication and Treatment - Storage Policy," last revised 10/2018, documented medications and treatments stored by the Community were to be stored in designated locations that must be locked when not in use or when unattended. Severity: 2 Scope: 3 Complaint #NV00070154			
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 the regulations adopted pursuant thereto.	0936	Please refer to original Statement of Deficiency/Plan of Correction - Event ID 8V4711.	05/15/2024

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0938 SS= F	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: (g) An evaluation of the resident ' s ability to perform the activities of daily living and a brief description of any assistance he or she needs to perform those activities. The facility shall prepare such an evaluation: (1) Upon the admission of the resident; (2) Each time there is a change in the mental or physical condition of the resident that may significantly affect his or her ability to perform the activities of daily living; and (3) In any event, not less than once each year.	0938	Please refer to original Statement of Deficiency/Plan of Correction - Event ID 8V4711.	05/15/2024
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) 3. 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 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 assigned interaction group of not more than six residents on the Country, Garden, Cottage, and Boat units during residents' waking hours in an Alzheimer's	0966	1) Community will schedule staffing to comply with the 6:1 ration during waking hours. 2) Staffing schedule will be reviewed daily to update resident census as needed and to verify that staff is scheduled to comply with ratio. 4) Executive Director or designee will monitor staffing schedule and ratio daily. 5) Corrective action has been implemented 6/27/24. 6) See attached supporting documentation.	06/27/2024

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	endorsed facility. Findings include: Review of the April 2024 and May 2024 staffing schedules documented the facility failed to provide a minimum of one caregiver for no more than six resident assigned interaction groups residing at the facility, which was endorsed for Alzheimer's Disease. The census for April 2024 was as follows: -29 on April 7 through 14, -30 on April 15 through 18, -31 on April 19 through 22, -32 on April 23 through 25, -31 on April 26, -32 on April 27 through 28, -33 on April 29, -and 32 on April 30. The census required five staff members April 7 through 18, and six staff members starting April 19 through 30, during resident waking hours. The census for May 2024 was 32 on May 1 through 15. Residents in the facility were roomed in four separate wings of the facility. On 05/15/2024, the facility lacked documented evidence of staff assignments on the staffing schedule for the aforementioned dates, defining the interaction groups on each unit in the facility. On 05/15/2024, the facility's staffing schedule did not meet the staffing requirement on each unit of one caregiver for every assigned interaction group of not more then six residents during the residents' waking hours in an Alzheimer's endorsed facility. On 05/15/2024 at 3:39 PM, the Health and Wellness Director (HWD) verbalized the HWD's understanding of the staffing regulations for an Alzheimer's endorsed facility required one caregiver for every six residents. The HWD confirmed the facility only had one caregiver assigned to each unit during waking hours and one caregiver as a floater. The HWD verbalized the Medication Technician did not have caregiving assignments for specified residents. The HWD confirmed there were six or more residents on each of the four units in the facility during the staffing review period of April 7, 2024 through May 15, 2024. The HWD verbalized not understanding that each unit with a census over six resident would require more than			

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	one caregiver assigned on each unit. The HWD confirmed the facility did not meet the daily staffing requirements on each unit where the individual unit census exceeded six residents. On 05/15/2024 at 4:10 PM, the Administrator confirmed the facility's staffing was not based on the census of each of the facility's four units, but was based on the total census of the facility. The Administrator confirmed the caregiver staffing during the staffing review period of April 7, 2024 through May 15, 2024, did not meet the staffing requirement for a facility with an Alzheimer's endorsement for each unit. This was a repeat deficiency from the State annual survey on 09/21/2023. Severity: 2 Scope: 3 Complaint #NV00070154			

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0994 SS= D	Alzheimer 's Care Standards for Safety - NAC 449.2756 and R043-22 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 or other forms of dementia who meet the criteria prescribed in paragraph (a) of subsection 2 of NRS 449.1845 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 facility failed to ensure resident safety in the memory care unit by securing hazardous chemicals for 32 of 32 residents. Findings include: On 05/15/2024, the following rooms contained dangerous items: - At 10:07 AM, Room 2 container a razor in the nightstand On 05/15/2024 at 10:26 AM through 10:44 AM, the Maintenance Director confirmed the razor could be dangerous to residents in the memory care unit and should be secured. The facility policy, "Resident Personal Care Items - ALZ-5," documented, "it is important that all areas of the community are made as safe as possible." Severity: 2 Scope: 1	0994	1) Correction will include inspection of resident rooms and removal or storage of items that may be dangerous to residents. 2) Resident rooms will be inspected daily by shift leads or Executive Director, Health and Wellness Director or designee. 4) The Executive Director will be responsible for implementing this plan of correction. 5) The corrective action will be implemented on 6/28/24. 6) See attached supporting documentation.	06/27/2024
0999 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 and R043-22 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 or other forms of dementia who meet the criteria prescribed in paragraph (a) of subsection 2 of NRS 449.1845 shall ensure that: (g) All toxic substances are not accessible to the residents of the facility. Inspector Comments: Based on observation	0999	1) Inspection of resident rooms and removal or storage of items that my be considered toxic to residents. 2) Resident rooms will be inspected daily by shift leads or Executive Director, Health and Wellness Director or designee. 4) The Executive Director will be responsible for implementing this plan of correction. 5) The corrective action will be implemented on 6/28/24 6) See attached supporting documentation.	06/27/2024

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	and interview the facility failed to ensure resident safety in the memory care unit by securing hazardous chemicals for 32 of 32 residents. Findings include: On 05/15/2024, the following toxic items were present: - At 10:07 AM, in Room 2, there was: - a 1.5-ounce tube of Sparkle Fresh toothpaste - At 10:11 AM, in Room 4, there was: - a 32-ounce container of Lavender Castille soap - At 10:17 AM, in Room 5, there was: - four small bottles of essential oils - a container of Perineal Skin Cleanser - a four-ounce container of Remedy Intensive Skin Therapy Calazine zinc oxide paste - At 10:17 AM, in Room 3, there was: - an eight-ounce container of Bath & Body Woks aromatherapy lotion - At 10:24 AM, in Room 7, there was: - a 4.1-ounce container of Bedside Care foam - a four-ounce container of Remedy Clinical Protect - a four-ounce container of fresh scent shampoo/conditioner. - At 10:17 AM, in Room 5, there was: - four small bottles of essential oils - a container of Perineal Skin Cleanser - a four-ounce container of Remedy Intensive Skin Therapy Calazine zinc oxide paste - At 10:29 AM, in Room 11, there was: - a four-ounce container of Remedy Intensive Skin Therapy - a container of Suave 24-Hour deodorant - a 10-ounce container of Vaseline lotion - At 10:34 AM, in Room 12, there was: - a 28 milliliter container of No-Sting skin prep - a 0.14-ounce packet of Thera Calazinc Body Shield - two adhesive remover wipes - a container of Vital collagen powder - At 10:44 AM, in the Garden satellite kitchen, the cabinet storing utensils, including butter knives, was unlocked - At 10:46 AM, in Room 20, there was: - a 2.4-ounce tube of Crest adult toothpaste - At 10:57 AM, in Room 26, there was: - a 2.1-ounce tube of Colgate Sensitive toothpaste - At 11:02 AM, in Room 27, there was: - a 3.4-ounce tube of Sensodyne Proenamel toothpaste - At 11:04 AM, in Room 29, there was: - a container of Coppertone Complete sunscreen - a container of Softsoap body			

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	wash - a container of Degree deodorant - a container of Remedy shampoo & body wash - a container of Medline Soothe & Cool cleanse - a container of Theraworx Protect - At 11:15 AM, in Room 34, there was: - an 8.5-ounce container of Tena Proskin cleansing cream - At 11:24 AM, in Room 42, there was: - a two-ounce container of Plumaria lotion - a four-ounce container of coconut-papaya lotion - a container of Banana Boat sunscreen - At 11:28 AM, in Room 39, there was: - a 22-ounce container of Dove Sensitive Skin lotion - At 11:30 AM, in Room 44, there was: - a four-ounce tube of Clinpro 5000 Anti-Cavity toothpaste - a tube of Crest Plus Scope toothpaste - an 18-ounce container of Act Anticavity Fluoride mouthwash - a 6.7-ounce container of Clinique moisturizing lotion - a 15-ounce container of lavender honey baby powder - At 11:38 AM, in Room 44, there was: - a 4.3-ouce container of Crest adult toothpaste - a travel-size container of Crest adult toothpaste - a 21-ounce container of Jergens lotion On 05/15/2024 at 10:07 AM through 11:38 AM, the Maintenance Director confirmed the items were toxic and accessible to residents. The facility policy, "Resident Personal Care Items - ALZ-5," documented, "it is important that all areas of the community are made as safe as possible." This was a repeat deficiency from the 09/21/2023 annual State Licensure survey. Severity: 2 Scope: 3			
1001	Elderly Care Training for Caregivers - NAC 449.2758 Residential facility which provides care for elderly persons or persons with disabilities: Training for caregivers. (NRS 449.0302) 1. Within 60 days after being employed by a residential facility for elderly persons or persons with disabilities, a caregiver must receive not less than 4 hours of training related to the care of those residents.	1001	Please refer to original Statement of Deficiency/Plan of Correction - Event ID 8V4711.	05/15/2024

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1036 SS= F	Care to Persons with Dementia - NAC 449.2768 and R043-22 Residential facility which provides care to persons with dementia: Training for employees. (NRS 449.0302, 449.094) 1. Except as otherwise provided in subsection 2, the administrator of a residential facility which provides care to persons with any form of dementia shall ensure that: (a) Each employee of the facility who has direct contact with and provides care to residents with any form of dementia, including, without limitation, dementia caused by Alzheimer ' s disease, successfully completes: (2) In addition to the training requirements set forth in subparagraph (1), within 3 months after such an employee is initially employed at the facility, at least 8 hours of tier 2 training.	1036	Please refer to original Statement of Deficiency/Plan of Correction - Event ID 8V4711.	05/15/2024

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1037 SS= F	Care to Persons with Dementia - NAC 449.2768 and R043-22 Residential facility which provides care to persons with dementia: Training for employees. (NRS 449.0302, 449.094) 1. Except as otherwise provided in subsection 2, the administrator of a residential facility which provides care to persons with any form of dementia shall ensure that: (a) Each employee of the facility who has direct contact with and provides care to residents with any form of dementia, including, without limitation, dementia caused by Alzheimer ' s disease, successfully completes: (3) If such an employee is licensed or certified by an occupational licensing board, at least 3 hours of continuing education in providing care to a resident with dementia, which must be completed on or before the anniversary date of the first date the employee was initially employed at the facility. The requirements set forth in this subparagraph are in addition to those set forth in subparagraphs (1) and (2), may be used to satisfy any continuing education requirements of an occupational licensing board, and do not constitute additional hours or units of continuing education required by the occupational licensing board. (4) If such an employee is a caregiver, other than a caregiver described in subparagraph (3), at least 3 hours of tier 2 training in providing care to a resident with dementia, which must be completed on or before the anniversary date of the first date the employee was initially employed at the facility. The requirements set forth in this subparagraph are in addition to those set forth in subparagraphs (1) and (2).	1037	Please refer to original Statement of Deficiency/Plan of Correction - Event ID 8V4711.	05/15/2024
1540 SS= D	Cultural Competency Training - Cultural Competency Training R016-20 Sec. 14 1. Pursuant to subsection 1 of NRS 449.103, within 30 business days after the course or program is assigned a course number by the Division pursuant to section 18 of this regulation or within 30 business days of any agent or employee being contracted or	1540	1) Current staff have received Cultural Competency training and missing employee has completed training. New hires will receive Cultural Competency training within 30 days of employee being hired. 2) Using the Resident Assistant	06/25/2024

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	hired, whichever is later, and at least once each year thereafter, a facility shall conduct training relating specifically to cultural competency for any agent or employee of the facility who provides care to a patient or resident of the facility so that the agent or employee may: (a) More effectively treat patients or care for residents, as applicable; and (b) Better understand patients or residents who have different cultural backgrounds, including, without limitation, patients or residents who fall within one or more of the categories in paragraphs (a) to (f), inclusive, of subsection 1 of NRS 449.103. R016-20 Sec. 14 2. The facility shall provide the training required by subsection 1 through a course or program that is approved by the Director of the Department or his or her designee pursuant to section 17 of this regulation and is assigned a course number by the Division pursuant to section 18 of this regulation. R016-20 Sec. 14 3. The facility shall keep documentation in the personnel file of any agent or employee of the facility of the completion of the cultural competency training required pursuant to subsection 1. R016-20 Sec. 15 1. Within 90 days after a facility is licensed to operate, the facility must submit to the Department on a form prescribed by the Department the course or program which the facility will use to provide cultural competency training. The facility may: (a) Develop or operate the course or program; or (b) Contract with a third party to develop and operate the course or program. R016-20 Sec. 15 2. The course or program submitted by the facility pursuant to subsection 1 must address patients or residents who have different cultural backgrounds from that of the agent or employee of the facility, including, without limitation, patients or residents who fall within one or more of the categories in paragraphs (a) to (f), inclusive, of subsection 1 of NRS 449.103. R016-20 Sec. 15 3. When a facility submits a course or program pursuant to subsection 1, the		Orientation Checklist to track their progress, new hires will undergo required training, namely, Cultural Competency within 30 days of their orientation and training schedule and agenda (agenda is also sent to new hires). The Checklist will be signed by an assigned trainer and dated when completed. This Checklist will be required to be completed prior to resident contact. 3) This corrective action will be monitored for completion using the Resident Assistant Orientation Checklist which will be attached to the employee file. 4) The Business Office Coordinator will be responsible for monitoring the progress of the new employee training and orientation schedule. The Executive Director will verify that completion of required trainings are completed prior to resident contact. 5) Corrective action including Orientation Checklist has been implemented on 6/25/24. 6) See attached supporting documentation.	

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	facility must also provide to the Department the following information for the instructor of the course or program: (a) The application of the instructor who will teach the course or program; (b) Three letters of recommendation for the instructor, including, without limitation, at least one letter of recommendation in which the recommender has knowledge of the methods the instructor uses in teaching a cultural competency course or program; and (c) The resume of the instructor of the course or program that includes, without limitation, the education, training and experience the instructor has in providing cultural competency training. R016-20 Sec. 15 4. Except as otherwise provided in subsection 5, when a facility submits a course or program pursuant to subsection 1, the facility must also provide to the Department: (a) The syllabus of the course or program; (b) The following information: (1) The name of the facility; (2) The address of the facility; (3) The electronic mail address of the facility; (4) The license number of the facility; and (5) The name and contact information of a person who represents the facility and who can discuss the course or program submitted by the facility pursuant to subsection 1; (c) If the facility contracts with a third party who develops and operates the course or program, the following information: (1) The name of the third party; (2) The address of the third party; (3) The electronic mail address of the third party; and (4) The name and contact information of a person who represents the third party and who can discuss the course or program submitted by the facility pursuant to subsection 1; (d) Evidence that the subjects covered by the course or program include, without limitation, the course materials required by section 16 of this regulation; (e) A sample sign-in sheet for the course or program that contains: (1) The dates of the course or program; and (2) A place for a participant of the course or program to print and sign his			

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	or her name; (f) A sample evaluation form that a participant of the course or program may complete at the end of the course or program which evaluates: (1) The content of the course or program; (2) The instructor of the course or program; and (3) The manner in which the course or program is presented to the participant; and (g) A sample document that a participant of the course or program may complete at the end of the course or program in which the participant can perform a self-evaluation. R016-20 Sec. 15 5. A facility may submit a course or program pursuant to subsection 1 without submitting the information required in subsection 4 if the course or program: (a) Is provided by: (1) A nationally recognized organization, as determined by the Director of the Department; (2) A federal, state or local government agency; or (3) A university or college that is accredited in the District of Columbia or any state or territory of the United States; and (b) Provides proof of completion upon the participant of the course or program completing the course or program that the Director or his or her designee determines to be satisfactory. R016-20 Sec. 15 6. When a facility submits pursuant to subsection 1 a course or program that is described in subsection 5, the facility must also provide to the Department: (a) The name of the course or program; (b) The name of the organization, agency, university or college providing the course or program; (c) If the course or program is provided online, the URL of the course or program; (d) If the course or program is provided through a training system, access to the training system; (e) If the course or program is not provided online or through a training system, the syllabus of the course or program; (f) The following information: (1) The name of the facility; (2) The address of the facility; (3) The electronic mail address of the facility; (4) The license number of the facility; and (5) The name and contact information of a person who represents the facility and who			

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	can discuss the course or program submitted by the facility pursuant to subsection 1; and (g) Any other information the Department requests to assist the Director or his or her designee in determining whether or not to approve the course or program pursuant to section 17 of this regulation. 7. As used in this section, "URL" means the Uniform Resource Locator associated with an Internet website. R016-20 Sec. 16 1. A course or program subject to the requirements of subsection 4 of section 15 of this regulation must include, without limitation, the following course materials: (a) An overview of cultural competency; (b) An overview of implicit bias and indirect discrimination; (c) The common assumptions and myths concerning stereotypes and examples of such assumptions and myths; (d) An overview of social determinants of health; (e) An overview of best practices when interacting with persons who fall within one or more of the categories in paragraphs (a) to (f), inclusive, of subsection 1 of NRS 449.103; (f) An overview of gender, race and ethnicity; (g) An overview of religion; (h) An overview of sexual orientation and gender identities or expressions; (i) An overview of mental and physical disabilities; (j) Examples of barriers to providing care; (k) Examples of language and behaviors that are discriminatory; and (l) Examples of a welcoming and safe environment. R016-20 Sec. 16 2. The course materials included in a course or program, including, without limitation, the course materials required by subsection 1, must include, without limitation: (a) Evidence-based, peer-reviewed sources; (b) Source materials that are used in universities or colleges that are accredited in the District of Columbia or any state or territory of the United States; (c) Source materials that are from nationally recognized organizations, as determined by the Director of the Department; (d) Source materials that are published or used by federal, state or local government agencies;			

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	or (e) Other source materials that are deemed appropriate by the Department. R016-20 Sec. 17 4. The facility shall submit the additional information that the facility needs to submit pursuant to paragraph (b) of subsection 3 within 45 days after being notified that the course or program is not approved pursuant to paragraph (a) of subsection 3. Upon receiving the additional information, the Director or his or her designee may approve the course or program. If the additional information is not received or fails to include all of the information that the Director or his or her designee informed the facility that it needed to submit, the Director or his or her designee shall not approve the course or program. Inspector Comments: Based on personnel record review and interview, the facility failed to ensure cultural competency training was completed timely for 1 of 7 sampled employees required to obtain cultural competency training (Employee #1). Findings include: On 05/15/2024, the Business Office Coordinator was provided the Personnel Check List to complete for 10 sampled employees. On 05/15/2024, the Business Office Manager provided the completed form with the following information: Employee #1 Employee #1 was employed as Administrator on 04/02/2024. Employee #1's personnel file lacked a cultural competency training certificate. On 05/15/2024, the Executive Director provided the Attestation of Compliance form, signed and dated 05/15/2024, confirming the Business Office Manager had conducted a thorough review of the personnel records to determine compliance and any noncompliance found. The Executive Director verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. Severity: 2 Scope: 1			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**05/15/2024**

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

(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
1825 SS= F	I C Program Responsible Person and Designee - IC Program Responsible Person and Designee LCB File No. R048-22 Sec. 5 3. The program to prevent and control infections within the facility for the dependent developed pursuant to paragraph (a) of subsection 1 must provide for the designation of: (a) A primary person who is responsible for infection control; and (b) A secondary person who is responsible for infection control when the primary person is absent to ensure that someone is responsible for infection control at all times.	1825	Please refer to original Statement of Deficiency/Plan of Correction - Event ID 8V4711.	05/15/2024
1830 SS= F	Infection Control Required Training - Infection Control Required Training LCB File No. R048-22 Sec. 5 4. The persons designated pursuant to subsection 3 as responsible for infection control shall complete not less than 15 hours of training concerning the control and prevention of infections provided by the Association for Professionals in Infection Control and Epidemiology, Inc., the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the World Health Organization or the Society for Healthcare Epidemiology of America, or a successor in interest to any of those organizations, not later than 3 months after being designated and annually thereafter. 5. Training completed pursuant to subsection 4 may be in any format, including, without limitation, an online course provided for compensation or free of charge. A certificate of completion for the training must be maintained in the personnel file of each person designated pursuant to subsection 3 for 3 years immediately following the completion of the training.	1830	Please refer to original Statement of Deficiency/Plan of Correction - Event ID 8V4711.	05/15/2024