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RFG 0001-Deficiencies	The Statement of Deficiencies was generated as a result of a state licensure survey conducted in your facility, in accordance with Nevada administrative code, chapter 449, and Nevada revised statutes chapter 449- Residential Facility for Groups (RFG), medical facilities and other related entities. The findings and conclusions of any investigation by the Division of Health Care Purchasing and Compliance shall not be construed as prohibiting any criminal civil investigation, actions or other claims for reliefs that may be available to any party under applicable federal, state or local law. Based on an inspection conducted, the items marked below identify the violation in operation of the RFG which must be corrected by the revisit/compliance date specified in writing by the health authority. Failure to comply with this notice and immediately correct the identified deficiencies may result in the suspension or termination of your provider agreement, funding, or future authorization as a provider authorized by the State	RFG 0001-Deficiencies		

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	of Nevada pursuant to NAC 433.384, and other applicable local and state laws. Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation and mandatory re-grading survey completed at your facility on 11/05/2025. 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 50. Nine resident files were reviewed, and nine employee files were reviewed. The facility received a grade of C. There were three complaints investigated. Substantiated: 1. Complaint #NV00074703 was substantiated. (See Tag Y0590) 2. Complaint #NV00074106 was substantiated. (See Tag Y0878) Unsubstantiated: 3. Complaint #NV00074666 could not be substantiated. No regulatory deficiencies could be identified. The investigation of Complaints included: Observation of grooming and physical appearance for residents, staff to resident interactions and a tour of the facility. Interviews were conducted with residents, Caregivers, Medication Technicians and the Executive Director. Clinical Record Review of 12 records, including the residents of concern.			

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	Document Review included facility policy and procedures, incident investigations, and incident logs.			
Y 0179 SS= D	NAC 449.209 6. All windows that are capable of being opened in the facility and all doors that are left open to provide ventilation for the facility must be screened to prevent the entry of insects. Inspector Comments: Based on observation and interview, the facility failed to ensure the interior of the facility was clean, free of black widow spiders in rooms, and windowsills were in good repair. Findings include: On 11/05/2025 at 10:56 AM, located in the Cottage Place wing satellite kitchen, there was a warped window stool and had paint chipping away from the wood. On 11/05/2025 at 10:56 AM, the Sales Manager was unsure what caused the window stool to warp and confirmed the window stool was warped and had paint chipping from the wood. On 11/05/2025 at 11:08 AM, room 37 had feces on the seat, back, and bottom of the toilet and a black widow on the wall. On 11/05/2025 at 11:08 AM, the Sales Manager confirmed the toilet was covered in feces and there was a black widow on the wall. The Sales Manager explained pest control was coming out to the facility once a month to treat the facility; however, both concerns could cause a safety concern for the residents in the unit. Severity: 2 Scope: 1	Y 0179	1. The Cottage Place wing kitchen window stool was repaired. Room 37 was cleaned and pest control completed. 2. By following Brookdale's "Fresh Impressions" weekly of the community are observed to verify ongoing compliance with NAC 449.17. 3. Maintenance Manager or designee under the direction of the Executive Director will complete weekly Fresh Impressions audits. 4. Maintenance Manager under the direction of the Executive Director. 5. The items are completed as of 3/31/26. 6. Attached are pictures of the window sill, the pest control record from 11/8/25 and the "Fresh Impressions" guide.	03/31/2026
Y 0250 SS= F	NAC 449.217 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	Y 0250	1. The kitchen handwash sink was repaired. Quat buckets have been purchased. Satellite kitchen dish machines have been serviced, the refrigerators in the satellite kitchens have been cleaned. 2. Brookdale brought in additional corporate dining support for evaluation and training.	06/19/2026

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	for the sanitary preparation of food. The equipment must be in good working condition. 2. Perishable foods must be refrigerated at a temperature of 40 degrees Fahrenheit or less. Frozen foods must be kept at a temperature of 0 degrees Fahrenheit or less. 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. 4. The administrator of a residential facility shall ensure that there is at least a 2-day supply of fresh food and at least a 1-week supply of canned food in the facility at all times. 5. Pesticides and other toxic substances must not be stored in any area in which food, kitchen equipment, utensils or paper products are stored. Soaps, detergents, cleaning compounds and similar substances must not be stored in any area in which food is stored. Inspector Comments: Based on observation, interview, and document review, the facility failed to ensure 1) the kitchen had an operable handwashing sink to include hot water, 2) dishwashing machines were dispensing sanitizing and cleaning agents, 3) staff were aware of proper sanitizing and cleaning of dishes manually, 4) quat buckets contained sanitizing agents, 5) refrigerators were clean from food debris, and 6) various non-edible items were not stored with resident food. Findings include: On 11/05/2025 at 9:38 AM, the handwashing sink in the kitchen had no hot water. The handwashing sink was running with the nozzle on the hottest point for approximately two minutes and the water was cold to the touch.		3. The main kitchen and satellite kitchens will be assessed weekly by the dining services manager or delegate. The Executive Director will monitor the condition of the main kitchen weekly for the next 12 weeks. 4. Dining Services Manager as well as the Executive Director. 5. The kitchen was re-surveyed on 3/2/26. Staff Training on 3/11/26. 6. Training records attached.	

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	On 11/05/2025 at 9:38 AM, the Cook explained there was only one handwashing sink in the kitchen and all dietary staff used the handwashing sink to wash hands prior to and after handling food. The Cook explained the handwashing sink had a duel purpose and was also an eye-washing station. As a result, the hot water was shut off to the sink. The Cook confirmed the handwashing sink was only able to produce cold water and no hot water was available for staff to wash their hands. On 11/05/2025 at 2:15 PM, during a revisit to the kitchen, the Cook verbalized letting the water run in the handwashing sink for about 10 mins and still could not get the water to turn warm. On 11/05/2025 at 1:34 PM, the Administrator confirmed the handwashing sink was disconnected from receiving hot water and staff did not have hot water available from the handwashing sink to wash hands prior to and after handing resident food. The Administrator verbalized it would not be appropriate to have staff wash hands in the three-compartment sink because that sink was used to defrost meats, clean vegetables, and sanitize and disinfect resident dishes. On 11/05/2025 at 9:41 AM, the walk-in refrigerator had sliced mushrooms scattered all over the floor. In 11/05/2025 at 9:42 AM, the Cook confirmed the walk-in refrigerator had sliced mushrooms covering the floor and was unsure how long the mushrooms had been lying on the floor. The Cook explained when food was spilled, the food was to be cleaned right away by staff. On 11/05/2025 at 9:44 AM, one quat bucket was available in the kitchen. The quat bucket was dry and did not contain a sanitizing agent. On 11/05/2025 at 9:44 AM, the Cook confirmed the kitchen only had one quat bucket and the bucket did not contain any sanitizing agent. The Cook verbalized			

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	breakfast service had just ended was not sure how staff disinfected the kitchen prior to and after handling food. The Cook explained quat buckets were to be full at all times with a sanitizing agent to be able to disinfect surfaces in the kitchen. On 11/05/2025 at 9:44 AM, the three-compartment sink used to wash, rinse, and sanitize dishes was empty and dry to the touch. On 11/05/2025 at 9:44 AM, the Cook confirmed there was no solution in the three-compartment sink to be able to sanitize and disinfect used dishes and verbalized the Cook forgot to fill the sink upon the start of shift. On 11/05/2025 at 9:45 AM, located on the top of the ice machine was the following items: -One walkie talkie, -A Shasta soda, -A box cutter, -A set of keys, -Paperwork, -A box, -A plastic grocery bag, -Tape, -One clip board; and, -Hairnets On 11/05/2025 at 9:48 AM, the Cook explained staff usually don't keep "this much stuff" on top of the ice machine because storing of items with food and drink served to residents could cause cross contamination. The Cook confirmed storing items on top of the ice machine used for residents. On 11/05/2025 at 9:50 AM, located in the dry storage food area, on top of a shelf with resident food, were the following items: -a tape gun, -three pictures that hang on a wall; and, -a roll of twine. On 11/05/2025 at 9:52 AM, the Administrator confirmed random items were being stored with resident food and explained non-food items were not to be			

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	stored with resident food. On 11/05/2025 at 10:28 AM, located in the Garden wing satellite kitchen, the dishwasher was not dispensing sanitizer, during a cycle, to sanitize used resident dishes. On 11/05/2025 at 10:28 AM, the Sales Manager confirmed no sanitizer was being dispensed into the dishwasher during cycles. On 11/05/2025 at 10:36 AM, the Maintenance manager confirmed sanitizer was not being dispensed into the dishwasher during a cycle and when using test strips to determine the strength of sanitizer during a cycle did not change color indicating a sanitizing agent in the water. The Maintenance manager started another cycle in the dishwasher and observed the sanitizing agent and the detergent were not being dispensed. On 11/05/2025 at 11:17 AM, located in the Garden wing satellite kitchen, the dishwasher was not dispensing sanitizer, during a cycle, to sanitize and clean used resident dishes. On 11/05/2025 at 11:17 AM, the Sales Manager confirmed the dishwasher was not dispensing the sanitizing agent and the detergent to be able to disinfect used resident dishes. On 11/05/2025, located in the Boat House wing satellite kitchen, the dishwasher was not dispensing sanitizer, during a cycle, to sanitize and clean used resident dishes. On 11/05/2025 at 12:17 PM, located in the Country Lane wing satellite kitchen, the dishwasher was not working. On 11/05/2025 at 12:17 PM, the Caregiver confirmed the dishwasher was inoperable for approximately three weeks and explained all soiled resident dishes were transported to the main kitchen to be hand washed. Once the dishes were handwashed, the dishes were brought back			

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	to Country Lane for residents to use. The Caregiver verbalized not using sanitizer with the dishes brought to the kitchen and expressed not being trained on how to properly clean the resident dishes. On 11/05/2025 at 1:34 PM, the Administrator confirmed three of four satellite kitchen dishwashers were not dispensing sanitizing agents and detergent agents. The Administrator confirmed one of four satellite kitchen dishwasher was inoperable and staff were taking the dishes to the kitchen to be washed and no staff were trained on sanitizing dishes. On 11/05/2025 at 11:42, located in the Boat House wing satellite kitchen, the reach in refrigerator had fluid and a sticky unknown substance in the bottom of the refrigerator. On 11/05/2025 at 11:42 AM, the Sales Manager confirmed there was an unknown fluid and sticky substance in the bottom of the reach in refrigerator and verbalized the refrigerator needed to be cleaned. The facility policy titled “Infection Prevention and Control Plan for Group Homes-Nevada”, effective on 10/06/2020, documented hand hygiene was to be performed before, during, and after preparing food. Hand washing was to be done with soap and water for at least 20 seconds. The facility policy titled “Handwashing/Hand Hygiene IC-13”, effective on 10/2021, documented regular hand washing and hand hygiene was the primary means to prevent the spread of infections. Hand hygiene products, such as sinks, would be readily accessible and convenient for staff to use to remain in compliance with hand hygiene policies. The facility policy titled “Washing and Sanitizing Dishes (Manual Wash)”, last revised 12/2024, documented any items needing to be washed manually would be washed and sanitized using manual washing procedures. The procedure would include stacking dirty dishes near the			

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	washing three-compartment sink. Rinse the dishes thoroughly and dispose of excess food in the garbage disposal or leak proof container. Fill the first compartment of the sink with hot water between 110 degrees Fahrenheit (F)-120 F and ware washing detergent. Next, submerge the dishes and wash thoroughly. Submerge the rinsed dishes in the third sanitizing compartment of the sink for a minimum of two minutes. The tank must contain water with approved sanitizing agent at a proper concentration. Last, let the dishes air dry on a sanitized drain board. The facility policy titled “Washing and Sanitizing Dishes (Machine Wash)”, last revised 12/2024, documented all dishes, glassware, and utensils would be washed and sanitized using commercial machine-washing procedures. The procedures included to pre-rinse all dishes and ensure there was no food residue on the dishes. Ensure the dishwashers all reached an approved temperature. For a low temperature dishwasher, the temperature needed to reach a minimum of 120 F. The facility policy titled “Food Storage – DS – 04.013”, last revised June 2024, documented all food storage areas were to remain free from dirt, dust, insects, rodents, or any potential sources of contamination. The proper storage of food would maximize nutrient retention, quality, and food safety. The facility policy titled “Kitchen Cleaning”, effective on 07/2025, documented all kitchens and food preparation areas must be cleaned according to federal, state, and local regulations. Food service equipment was cleaned per the cleaning schedule and sanitized after each use. Food service areas, such as counters, drawers, cupboards, prep areas, cutting boards, and bus carts/trays were to be cleaned and sanitized. Severity: 2 Scope: 3			
Y 0590 SS= D	NAC 449.268	Y 0590	1. As stated in the review, the caregiver identified in the complaint was immediately put on suspension and subsequently	03/11/2026

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	Rights of residents; procedure for filing grievance, complaint or report of incident; investigation and response. 1. The administrator of a residential facility shall ensure that: (a) The residents are not abused, neglected or exploited by a member of the staff of the facility, another resident of the facility or any person who is visiting the facility; (b) A resident is not prohibited from speaking to any person who advocates for the rights of the residents of the facility; (c) The residents are treated with respect and dignity; (d) The facility is a safe and comfortable environment; (e) Residents are not prohibited from interacting socially; (f) Residents are allowed to make their own decisions whenever possible; (g) Residents are aware that they may file a complaint or grievance with the administrator and that a resident who files such a complaint receives a response in a timely manner; (h) A resident is informed as soon as practicable that he is being moved to a new room or that he is receiving a new roommate; and (i) Residents are afforded the opportunity to initiate an advance directive or power of attorney for health care and that the employees of the facility comply with the wishes contained in such a document. 2. The administrator of a residential facility shall provide a procedure to respond immediately to grievance, incidents and complaints. The procedure must include a method for ensuring that the administrator or a person designated by the administrator		terminated. 2. Ongoing staff training was completed in regards to abuse, neglect and reporting. 3. Management team members will continue to monitor/report signs of potential abuse/neglect. 4. Team members under the direction of the Executive Director. 5. Staff training completed on 3/11/2026. 6. Staff training records attached.	

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	is notified of the grievance, incident or complaint. The administrator or a person designated by the administrator shall personally investigate the matter. A resident who files a grievance or complaint or reports an incident pursuant to this subsection must be notified of the action taken in response to the grievance, complaint or report or be given a reason why no action needs to be taken. 3. The employees of the facility shall comply with the procedures adopted pursuant to subsection 2. Inspector Comments: Based on record review, interview, and document review, the Administrator failed to ensure 1 of 9 sampled residents (Resident #4) was kept safe from physical abuse. Findings include: Resident #4 Resident #4 was admitted to the facility on 06/13/2023 with diagnoses including dementia, hypothyroidism, and hypertensive heart disease. Resident #4's clinical record included a progress note dated 01/17/2025 at 5:10 PM documenting a witness observed Resident #4 was brought into the dining room and slapped by a facility associate. The facility incident log documented on 03/17/2025 at 5:05 PM, a Caregiver1 (CG1) was observed in the dining room with Resident #4. CG1 slapped the resident's right cheek with an open palm. A form titled "Incident Investigation," dated 03/17/2025, documented the following: -At 5:07 PM, a Visitor reported observing CG1 move Resident #4 from the living room to the dining room and slap the resident on the cheek with the palm of CG1's hand.			

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	-At 5:45 PM, CG1 was interviewed by the previous Health and Wellness Coordinator (HWC) and CG1 recounted CG1's interactions with Resident #4. When CG1 began work on 03/17/2025, Resident #4 was asleep with the resident's wheelchair in the living room. CG1 verbalized around dinner time, CG1 wheeled Resident #4 into the dining room. CG1 was suspended pending an investigation. -At 6:05 PM, Resident #4 was observed by the HWC to have redness on the resident's right cheek compared to the left side. -At 6:10 PM, the Visitor was interviewed by the HWC and explained on 03/17/2025 at approximately 5:07 PM, the Visitor observed CG1 move Resident #4 from the living room to the dining room and slap the resident's right cheek with the open palm of CG1's hand. The Visitor immediately notified facility leadership. A facility form titled "Corrective Action Category: Unacceptable Behavior," dated 03/31/2025, documented on 03/17/2025, an allegation was reported CG1 acted aggressively toward a resident. A visitor witnessed CG1 slap a resident on the cheek while bringing the resident into the dining room. The resident was found to have evidence verifying CG1's behavior. The facility reviewed the witness statement and found it to be a credible report. The behavior described was in violation of the facility's guidelines for appropriate conduct On 11/05/2025 at 2:23 PM, a Caregiver 2 (CG2) verbalized signs of physical abuse included markings on a resident's body, skin tears, or blemishes in the shape of fingers or nails. CG2 verbalized being aware of the incident between Resident #4 and CG1. While CG2 was not present for the incident, CG2 explained CG2 observed CG1 behave aggressively toward other residents before the incident on 03/17/2025. CG2 reported this observed behavior to the previous HWC when it occurred; however, was unsure whether anything was done to address the concerns. On 11/05/2025 at 04:26 PM, the Executive Director (ED) verbalized on the date of the			

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	incident, the ED was not present in the facility. The HWC was notified CG1 slapped Resident #4 and the HWC commenced an investigation consisting of interviews with the resident, CG1, and the Visitor. The HWC “assessed” Resident #4 and found a red mark on the resident’s face. The ED was unaware of any previous allegations of abuse regarding CG1. The ED explained CG1 was ultimately terminated when the facility substantiated the allegation of abuse. An employee Elder and Abuse and Neglect training booklet, dated 07/2014, documented physical abuse was an act resulting in bodily harm, injury, impairment or disease, often taking the form of hitting or slapping. The facility policy titled “Abuse, Neglect and Exploitation Policy,” revised 05/2021, documented abuse was defined as willful and unjustified infliction of pain infliction of pain injury or mental anguish. Severity: 2 Scope: 1 Complaint #NV00074703			
Y 0515 SS= D	NAC 449.259 **Supervision of residents.** 1. A residential facility shall ensure that the staff of the facility collaborate with each resident of the facility, the family of the resident and other persons who provide care for the resident, including, without limitation, a qualified provider of health care, as interpreted by section 8 of this regulation, to: (a) Develop a person-centered service plan for the resident; and (b) Review the person-centered service plan at least once each year. 2. A person-centered service plan developed pursuant to this section must include, without limitation: (a) Provisions concerning activities of daily	Y 0515	1. Service Plan meeting signature obtained with the resident family that was reported on file. 2. Clinical team members have been re-trained on importance of gaining signature for service plan discussions. 3. Executive Director will review service plan records upon completion. 4. Clinical team members to obtain appropriate signatures under the supervision of the Executive Director. 5. Training to be complete and process in place with upcoming service plan meetings. 4/30/26 6. Attach signed service plan from most current review with family.	04/30/2026

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	living, medication management, cognitive safety, assistive devices, special needs, social and recreational needs and involvement of ancillary services; (b) Protective supervision as necessary for the resident; (c) The manner in which all caregivers will be informed of the required supervision of the resident; (d) The manner in which the facility will ensure that the resident has the opportunity to attend the religious service of his or her choice and participate in personal and private pastoral counseling; (f) Permission for the resident to enter or leave the facility at any time if the resident: (1) Is physically and mentally capable of leaving the facility; and (2) Complies with the rules established by the administrator of the facility for leaving the facility; (g) Laundry services for the resident unless the resident elects in writing to make other arrangements; (h) The manner in which the facility will ensure that the resident's clothes are clean, comfortable and presentable; (i) A requirement that the facility must inform the resident or his or her representative of the actions that the resident should take to protect the resident's valuables; (j) A written program of activities for the resident that includes scheduled and unscheduled activities that are suited to his or her interests and capacities; Inspector Comments: Based on record review and interview, the facility failed to ensure a person-centered service plan was reviewed with the resident and/or the resident's family or representative to address the facility's treatment of residents for 1 of 9 sampled residents reviewed for service plans (Resident #3). Findings include:			

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	Resident #3 Resident #3 was admitted to the facility on 10/19/2022, with diagnoses including vascular dementia and depression. Resident #3's clinical record included a service plan dated 09/25/2025. The clinical record lacked documentation of meeting and collaborating with the resident and/or the resident's family or representative in the development of the service plan. On 11/05/2025 at 3:02 PM, the Executive Director verbalized person-centered service plans were to be reviewed by the residents' family annually. The Executive Director explained Resident #3's 09/25/2025 service plan was reviewed with the resident's representative in July 2025; however, the representative refused to sign an attestation a review was completed until changes could be made to the service plan. The Executive Director confirmed the facility did not have documentation of the meeting and collaborating with resident's family or representative to develop Resident #3's service plan, nor did the facility document the refusal of a signature by the representative. The facility policy titled "Service Plan Process Policy," last revised 09/2025, documented the service plan should be completed and reviewed by the facility and the resident/legally responsible party. Severity: 2 Scope: 1			
Y 0690 SS= D	**NAC 449.2712** **Residents requiring use of oxygen.** 1. A person who requires the use of oxygen must not be admitted to a residential facility or be permitted to remain as a resident of a residential	Y 0690	1. Resident reviewed in survey no longer resides in the community. 2. Oxygen usage was added to the Medication Administration Record for liter flow check once each shift to verify accuracy of liter flow. 3. Wellness Director or designee will add Oxygen usage to the Medication Administration Record. Executive Director or designee will review residents with	07/01/2026

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	facility unless he: (a) Is mentally and physically capable of operating the equipment that provides the oxygen; or (b) Is capable of: (1) Determining his need for oxygen; and (2) Administering the oxygen to himself with assistance. 2. The caregivers employed by a residential facility with a resident who requires the use of oxygen shall: (a) Monitor the ability of the resident to operate the equipment in accordance with the orders of a physician; and (b) Ensure that: (1) The resident's physician evaluates periodically the condition of the resident which necessitates his use of oxygen; (2) Signs which prohibit smoking and notify persons that oxygen is in use are posted in areas of the facility in which oxygen is in use or is being stored; (3) Persons do not smoke in those areas where smoking is prohibited; (4) All electrical equipment is inspected for defects which may cause sparks. (5) All oxygen tanks kept in the facility are secured in a stand or to a wall; (6) The equipment used to administer oxygen is in good working condition; (7) A portable unit for the administration of oxygen in the event of a power outage is present in the facility at all		oxygen orders monthly for a period of 3 months to verify ongoing compliance. 4. Liter flow observed by Medication Technician once each shift under direction of the Health and Wellness Director. 5. Oxygen orders reviewed and added to record by April 30, 2026. .	

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	times when a resident who requires oxygen is present in the facility; and (8) The equipment used to administer oxygen is removed from the facility when it is no longer needed by the resident. 3. The administrator of a residential facility shall ensure that the caregivers who may be required to administer oxygen have demonstrated the ability to operate properly the equipment used to administer oxygen. Inspector Comments: Based on observation, interview, and document review, the facility failed to ensure a resident's Oxygen concentrator was not running while the resident was not being administered Oxygen, nor in the resident's room for 1 of 9 sampled residents (Resident #2). Findings include: Resident #2 Resident #2 was admitted to the facility on 05/26/2023, with diagnoses including dementia, hyperlipidemia, and chronic obstructive pulmonary disorder. A physician's order dated 04/17/2025, documented Oxygen at two liters per minute (LPM) via nasal canula at night. Offer Oxygen at two LPM as needed when resident was short of breath or requests Oxygen. On 11/05/2025 at 11:57 AM, Resident #2 was not located in the resident's room. At the foot of the bed was the resident's Oxygen concentrator and the concentrator was running at 3.5 LPM. On 11/05/2025 at 11:57 AM, the Sales Manager confirmed Resident #2 Oxygen concentrator was running in the resident's room while not currently administering Oxygen to the resident. On 11/05/2025 at 12:00 PM, a Caregiver			

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	confirmed Resident #2 Oxygen concentrator was running while not currently administering Oxygen to the resident. The Caregiver verbalized the resident may be eating lunch. On 11/05/2025 at 3:40 PM, the Wellness Director explained an Oxygen concentrator was not to be turned on and running while not administering to a resident and while the resident was not in the room. The Wellness Director verbalized the resident had a physician's order for 2 LPM at night and should not have been set at 3.5 LPM. The Wellness Director verbalized the Caregivers were to be checking on the LPM and Oxygen administration for the resident while the resident was being administered Oxygen. The Wellness Director explained the resident did not have a physician's order to titrate the Oxygen and the resident could have messed with the Oxygen concentrator prior to leaving the resident's room. Severity: 2 Scope: 1			
Y 0850 SS= D	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.** 1. If a resident of a residential facility becomes ill or is injured, the resident's physician and a member of the resident's family must be notified at the onset of illness or at the time of the injury. The facility shall: (a) Make all necessary arrangement to secure the services of a licensed physician to treat the resident if the resident's physician is not available; and (b) Request emergency services when such services are necessary. 2. A resident who is suffering from an illness or injury from which the resident is expected to recover within 14 days after the onset of the illness or the time of the injury may be cared for in the facility. The	Y 0850	1. The resident cited is no longer a resident of the community. 2. The Health and Wellness Director or designee will complete 5 chart audits weekly for the next 90 days to verify compliance with the annual requirements. 3. Executive Director or designee will monitor 4 resident records a week for a period of 8 weeks to verify compliance with annual provider visit. 4. The Health and Wellness Director or designee with oversight from the Executive Director. 5. The 90day audits will be completed by 7/1/26.	07/01/2026

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	decision as to the period within which the resident is expected to recover from the illness or injury and the needs of the resident must be made by the resident's physician or, if he is unavailable, by another licensed physician. 3. A written record of all accidents, injuries and illnesses of the resident which occur in the facility must be made by the caregiver who first discovers the accident, injury or illness. The record must include: (a) The date and time of the accident or injury or the date and time that the illness was discovered; (b) A description of the manner in which the accident or injury occurred or the manner in which the illness was discovered; (c) A description of the manner in which the members of the staff of the facility responded to the accident, injury or illness and the care provided to the resident. This record must accompany the resident if he or she is transferred to another facility. 4. The facility shall ensure that appropriate medical care is provided to the resident by: (a) A caregiver who is trained to provide that care; (b) An independent contractor who is trained to provide that care; or (c) A medical professional. 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. 6. The members of the staff of the facility shall: (a) Ensure that the resident receives the personal care that he requires. (b) Monitor the ability of the resident to care for his own health conditions and shall document in writing any significant change in his ability to care for those conditions. 7. This section does not prohibit a resident from rejecting medical care. If a resident rejects medical care, an employee of the facility shall record the rejection in writing and request that the resident sign that			

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	record as a confirmation of his rejection of medical care. If the resident rejects medical care that a physician has directed the facility to provide, the facility shall inform the resident's physician of that fact within 4 hours after the care is rejected. The facility shall maintain a record of the notice provided to the physician pursuant to this subsection. 8. As used in this section, "significant change" means a change in a resident's condition that results in a category 1 resident becoming a category 2 resident or otherwise results in an increase in the level of care required by the resident. Inspector Comments: Based on record review, document review, and interview, the facility failed to ensure a physical examination was completed annually and retained by the facility for 1 of 9 sampled residents (Resident #2). Findings include: Resident #2 Resident #2 was admitted to the facility on 05/25/2023 with diagnoses including dementia hyperlipidemia and chronic obstructive pulmonary disease. Resident #2's clinical record lacked documented evidence of an annual physical examination with a review of systems completed for 2024 or 2025. On 11/05/2025 at 3:02 PM, the Executive Director verbalized residents were to have physical examinations completed annually and the facility would retain the results on the physical examination to ensure the facility was aware of the resident's needs. The Executive Director explained Resident #2 had a physical examination completed by a physical therapist on 09/09/2025. However, the facility did not retain a copy of the physical examination.			

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	The facility document titled “Residency Agreement,” dated 07/31/2025, documented the resident would undergo an examination by the resident’s physician at least annually. Severity: 2 Scope: 1			
Y 0885 SS= D	**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 and note the destruction of the medication in the record maintained pursuant to NAC 449.2744. Inspector Comments: Based on observation, record review, and interview, the facility failed to ensure expired medications were destroyed on or before the expiration date for 1 of 9 residents (Resident #2). Findings include: Resident #2 Resident #2 was admitted to the facility on 05/26/2023, with diagnoses including dementia, hyperlipidemia, and chronic obstructive pulmonary disease.	Y 0885	1. Review of the resident cited has been completed to verify medications are currently on site. 2. A full pharmacy review was completed 11/20/25 of all residents medications/orders. 3. Cart audits will be completed weekly for the next 12 weeks by the Health and Wellness Director and/or designee to verify ongoing compliance. 4. Health and Wellness Director or designee with oversight from the Executive Director. 5. The 12 week cycle of audits will be completed by 6/26/26.	06/26/2026

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	On 11/05/2025 at 3:50 PM, during a review of Resident #2's medications and in the presence of the Medication Technician, an inhaler of Olodaterol HCl Inhalation Aerosol Solution, and Albuterol Sulfate Inhalation Aerosol was observed. The pharmacy label documented the following: -Olodaterol HCl Inhalation Aerosol Solution 2.5 microgram, inhale 2 puffs orally one time a day. The expiration date printed on the box was 08/21/2025. -Albuterol Sulfate Inhalation Aerosol Powder Breath Activated 108 mcg, inhale 2 puffs orally every 4 hours as needed for complaints of shortness of breath. The Medication Technician confirmed the medications were expired and explained the facility should have discarded and reordered the medication prior to the expiration date. Severity: 2 Scope: 1			
Y 0878 SS= E	NAC 449.2742 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	Y 0878	1. Review of the residents cited has been completed to verify ensure medication orders are accurate. 2. A full pharmacy review was completed 11/20/25 of all residents medications/orders. 3. Cart audits will be completed weekly for the next 12 weeks by the Health and Wellness Director and/or designee to ensure ongoing compliance. Staff re-training will occur to discuss use of PRN medications as indicated as well as steps to follow if there is question regarding accuracy of orders. 4. Health and Wellness Director or designee with oversight from the Executive Director. 5. The 12 week cycle of audits will be completed by 6/26/26.	06/26/2026

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	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 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 clinical record review and interview, the facility failed to ensure a resident's medications were filled and administered to a resident per physician orders for 2 of 9 sampled residents (Resident #1 and #5) and medications were on-site to administer as prescribed for 2 of 9 sampled residents (Resident #5 and #2). Findings include: Medications Not Administered as			

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	Prescribed Resident #1 Resident #1 was admitted to the facility on 05/24/2024, with diagnoses including dementia, anemia and hyperlipidemia. A physician order dated 10/03/2025, documented Lorazepam 0.5 milligram (mg) tablet, take one tablet by mouth once daily at 2:00 PM for increased agitation and restlessness after lunch. Resident #1's October and November 2025 Medication Administration Record (MAR), lacked documented evidence of Lorazepam 0.5 mg tablets being given to Resident #1 at the scheduled time. On 11/05/2025 at 3:11 PM, the Medication Technician verbalized the resident only received Lorazepam as needed and was not giving the medication to Resident #1 as prescribed. On 11/05/2025 at 3:40 PM, observed the resident wandering the hallway while gripping onto the railing for support. Resident #1 was saying "unbelievable" and "this is not real". A caregiver assisted Resident #1 to bed. Resident #1 was fidgety and was seen lifting hands and legs in the air, then began getting out of bed. When the caregiver asked what the resident was doing the resident relied "I'm not staying here". Resident #5 Resident #5 was admitted to the facility on 10/25/2023, with diagnoses including dementia, hyperlipidemia, and depression. A physician order dated 04/30/2025, documented Rexulti 0.5 mg tablet, take one tablet by mouth daily. Resident #5's October and November 2025 MAR, documented Rexulti 0.5 mg tablet, take one tablet by mouth daily. On 11/05/2025, during Resident #5's			

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	medication review, the prescribed Rexulti 1 mg tablet, take one tablet by mouth daily was present in the medication cart. On 11/05/2025 at 3:20 PM, the Medication Technician verbalized the resident was to receive one tablet a day of Rexulti. The Medication Technician was unable to determine if the resident was receiving 1 mg tablet or if the Medication Technician was cutting the 1 mg tablet to give the resident a 0.5 mg tablet. A physician order dated 04/23/2025, documented Nitrofurantoin (Macrobid) 100 mg capsule, take one capsule by mouth two times a day. Start date of 04/23/2025. Resident #5's April 2025 MAR, documented Resident #5 received the first dose of Macrobid 100 mg capsule on 04/28/2025. On 11/05/2025 at 10:32 AM, the Medication Technician verbalized when a new medication was ordered for a resident the process was to fax the new order to the pharmacy to ensure the medication would be received by the facility promptly. The Medication Technician was unsure what the delay was for Resident #5 to receive the new order for an antibiotic. On 11/05/2025 at 12:59 AM, the Executive Director and the Director of Clinical Services explained the expectation was to input the order into the Electronic Health Record MAR the same day it was received. The Director of Clinical Services confirmed it would not have been appropriate for an antibiotic to have been delayed in administration for five days. CPT #NV00074106 Medications Not On-Site Resident #5 Resident #5 was admitted to the facility on 10/25/2023, with diagnoses including dementia, hyperlipidemia, and depression. Resident #5's physician order, dated			

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	1884	A. BUILDING _____ B. WING _____	11/05/2025

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

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	10/23/2025, and October and November 2025 MAR documented the following: -Benzonatate 200 mg oral capsule, give one capsule by mouth every 12 hours as needed for cough. On 11/05/2025, during Resident #5's medication review, the prescribed Benzonatate capsule was not present in the medication cart and the MT could not locate the medication. On 11/05/2025 at 3:30 PM, the Medication Technician confirmed Resident #5's Benzonatate could not be located in the medication cart or the locked medication overflow cabinet. Resident #2 Resident #2 was admitted to the facility on 05/26/2023, with diagnoses including dementia, hyperlipidemia, and chronic obstructive pulmonary disease. Resident #2's physician order, dated 07/14/2025, and October and November 2025 MAR documented the following: -Melatonin 3 mg tablet, take one tablet by mouth at bedtime. -Atorvastatin Calcium 40 mg tablet, take one tablet by mouth at bedtime -Phenazopyridine Hydrochloride (HCl) 200 mg tablet, take one ablet by mouth every 8 hours as needed for painful urination. On 11/05/2025, during Resident #2's medication review, the prescribed Melatonin, Atorvastatin and Phenazopyridine HCl tablets were not present in the medication cart. On 11/05/2025 at 3:30 PM, the Medication Technician confirmed Resident #2's Melatonin, Atorvastatin and Phenazopyridine HCl could not be located in the medication cart or the locked medication overflow cabinet. Severity: 2 Scope: 2			

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Y 1035 SS= D	NAC 449.2768 **Residential facility which provides care to persons with Alzheimer's disease: Alzheimer's/dementia Training:** 1. Except as otherwise provided in subsection 2, the administrator of a residential facility which holds an endorsement as a residential facility which provides care to persons with Alzheimer's disease or other forms of dementia pursuant to NAC 449.2754 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, in addition to the training required by NAC 449.196: (1) Within the first 40 hours that such an employee works at the facility after he is initially employed at the facility, at least 2 hours of tier 2 training. (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. (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	Y 1035	1. The associate cited within the survey is no longer employed at Brookdale. 2. Associate education records will be audited to verify compliance with the requirements. 3. The Business Office Manager or designee with supervision from the Executive Director will run monthly reports reviewing ongoing education compliance. The Executive Director will review 4 associate files a week for a period of 8 weeks to verify ongoing compliance. 4. Business Office Manager with supervision from the Executive Director. 5. Associate File audit to be completed by 4/30/26.	05/29/2026

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	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). (b) The facility maintains proof of completion of the hours of training and continuing education required pursuant to this section in the personnel file of each employee of the facility who is required to complete the training or continuing education. 2. A person employed by a facility which provides care to persons with any form of dementia, including, without limitation, dementia caused by Alzheimer's disease, is not required to complete the hours of training or continuing education required pursuant to this section if he has completed that training within the previous 12 months. Inspector Comments: Based on personnel record review and interview, the Administrator failed to ensure 1) employees working at the facility less than one year received eight hours of dementia training within 90 days for the employee's start date for 1 of 9 sampled employees (Employee #8), and 2) employees providing care to residents with dementia completed an additional three hours of dementia training by the employee's hire anniversary date for 1 of 9 sampled employees (Employee #7). Findings include: Initial Employee #8 Employee #8 was hired by the facility as a medication technician with a start date of 06/30/2025. A document titled "Course Completion History," dated 11/05/2025, documented one half hour of dementia care training completed 07/03/2024, and four hours of dementia care training completed			

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	07/04/2025. Employee #8's personnel record lacked documentation of any other dementia care training completed by the employee. On 11/05/2025 at 2:19 PM, the Business Office Manager (BOM) confirmed employees were required to complete eight hours of dementia training within 90 days of hire. The BOM confirmed Employee #3 was short three and a half hours of dementia care training to meet the requirements. Annual Employee #7 Employee #7 was hired by the facility as a caregiver with a start date of 10/05/2023. A document titled "Course Completion History," dated 11/05/2025, documented one half hour of dementia care training completed 01/13/2025. Employee #7's personnel record lacked documentation of any other dementia care training completed between the employee's anniversary dates of 10/05/2024 and 10/05/2025. On 11/05/2025 at 2:19 PM, the BOM confirmed employees were required to complete three hours of dementia care training by the employee's anniversary date of hire. The BOM confirmed the half hour of dementia care training completed by Employee #7 and verbalized the employee did not have any other dementia care training completed. Severity: 2 Scope: 1			