Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9070	A. BUILDING _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENDA CARE	**1235 GLENDA WAY, RENO, NEVADA ,89509**

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a State Licensure annual grading survey conducted at your facility on 09/12/2024. This State Licensure Survey was conducted in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 30 Residential Facility for Group beds for elderly or disabled persons, 16 Category I residents and 14 Category II residents. The census at the time of the survey was 25. The sample size was ten residents and ten employees. The facility received a grade of D. Your facility has recieved a C or D grade for this inspection. NAC 449.27706 Resurvey: Application and fee; failure to comply. 2. If the Bureau issues a placard to a residential facility that includes a grade of "C" or "D," the administrator must submit an application to the Bureau for a resurvey of the facility not later than 30 days after the facility receives the placard. The fee for an application for a resurvey is $600 and must accompany the application. 3. The Bureau may revoke the license of a residential facility that is required to submit an application for a resurvey pursuant to subsection 2 if the facility fails to submit the application in accordance with the provisions of that subsection. The following deficiencies were identified:	0000		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: SCOTT REDDY Title: Administrator Date: 11/29/2024

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0178 SS= F	Health & Sanitation - Maintain Int/ext - NAC 449.209 Health and sanitation. (NRS 449.0302) 5. The administrator of a residential facility shall ensure that the premises are clean and that the interior, exterior and landscaping of the facility are well maintained. Inspector Comments: Based on observation and interview, the facility failed to ensure the facility premisis were maintained in a clean and uncluttered manner. Findings include: On 09/12/2024 at 9:39 AM, in the backyard at the garbage cans, there were two chairs, four walkers, two wheelchairs, and a bed stored. On 09/12/2024 at 9:39 AM, the Administrator confirmed items should not be stored in the backyard and created clutter. Severity: 2 Scope: 3	0178	These items were staged outside in preparation for a trip to the dump. The items have now been removed. From now on, items being prepared for disposal will be staged at a different Property. The administrator will be responsible for this corrective action. This Corrective Action is already complete.	10/11/2024
0515 SS= F	Supervision and Treatment of Residents - NAC 449.259 & R043-22 Supervision and treatment of residents generally. (NRS 449.0302) 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.; Inspector Comments: Based on clinical	0515	A Person-Centered Plan of Care form has been prepared and the Plan will be completed for each resident with input from the residents as	11/12/2024

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	record review, document review and interview, the facility failed to develop a person-centered service plan addressing all required focus areas and interventions for 10 of 10 sampled residents (Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, and #10), affecting 25 of 25 residents in the facility. Findings include: The following residents lacked a person-centered service plan addressing all the required elements during the residents' clinical record review: - Resident #1 was admitted to the facility on 12/11/2023, with diagnoses including Parkinson's disease and hypertension. - Resident #2 admitted to the facility on 03/01/2024, with diagnoses including hydrocephalus and neuropathy. - Resident #3 was admitted to the facility on 03/25/2024, with diagnoses including essential hypertension, atrial fibrillation, and mild cognitive impairment. - Resident #4 was admitted to the facility on 06/29/2024, with diagnoses including chronic obstructive pulmonary disease and type two diabetes mellitus without complications. - Resident #5 admitted to the facility on 06/08/2018, with diagnoses including dementia with behavioral disturbance and anxiety. - Resident #6 was admitted to the facility on 08/22/2024, with diagnoses including basal cell carcinoma, bipolar disorder and hepatitis C. - Resident #7 was admitted to the facility on 12/19/2018, with a diagnosis of dementia. - Resident #8 was admitted to the facility on 09/29/2017, with diagnoses including bipolar disorder, major depressive disorder, and fibromyalgia. - Resident #9 admitted to the facility on 02/16/2024, with diagnoses including incontinence, memory problem, and chronic systolic heart failure. - Resident #10 was admitted to the facility on 11/17/2023, with diagnoses including dementia without behavioral disturbance and type II diabetes mellitus. On 09/12/2024 at 12:06 PM, the Administrator confirmed the facility lacked person-centered service plans for all residents in the facility. Severity: 2 Scope: 3		best as possible. The Administrator will be responsible for this Corrective Action. This Corrective Action will be completed by 11-12-2024. The Administrator is working to improve the Person-Centered Plan of Care with the guidance provided by the lead Surveyor. The Administrator will be responsible for this corrective action. This corrective action will be completed by 11-29-2024.	
0871	Medication Administration - Plan - NAC	0871		10/11/202

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SS= F	449.2742 and R043-22 Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall: d) Develop and maintain a plan for managing the administration of medications at the residential facility, including, without limitation: (1) Preventing the use of outdated, damaged or contaminated medications; (2) Managing the medications for each resident in a manner which ensures that any prescription medications, over-the-counter medications and nutritional supplements are ordered, filled and refilled in a timely manner to avoid missed dosages; (3) Verifying that orders for medications have been accurately transcribed in the record of the medication administered to each resident in accordance with NAC 449.2744; (4) Monitoring the administration of medications and the effective use of the records of the medication administered to each resident; (5) Ensuring that each caregiver who administers a medication is in compliance with the requirements of subsection 6 of NRS 449.037 and NAC 449.196; (6) Ensuring that each caregiver who administers a medication is adequately supervised; (7) Communicating routinely with the prescribing physician, physician assistant or advanced practice registered nurse or other physician, physician assistant or advanced practice registered nurseof the resident concerning issues or observations relating to the administration of the medication; and (8) Maintaining reference materials relating to medications at the residential facility, including, without limitation, a current drug guide or medication handbook, which must not be more than 2 years old or providing access to websites on the Internet which provide reliable information concerning medications. (e) Develop and maintain a training program for caregivers of the residential facility who administer medication to residents, including, without limitation, an initial orientation on the plan for managing medications at the facility for each new caregiver and an annual training update on		We have developed a new Medication Management Plan for the facility. The owner is responsible for this Corrective Action. This Corrective Action is already complete.	4

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	the plan. The administrator shall maintain documentation concerning the provision of the training program and the attendance of caregivers. Inspector Comments: Based on observation and interview, the facility's Administrator failed to implement and maintain a plan for the management of medications and ensure caregivers who administered medications in the facility were oriented and trained on the facility's plan for managing medications. Findings include: On 09/12/2024, the facility lacked a Medication Plan for the facility. On 09/12/2024 at 12:06 PM, the Administrator could not produce a written facility policy and verbalized the facility did not have a Medication Plan. Severity: 2 Scope: 3			
0878 SS= D	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 a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the	0878	A Medication Audit Process will be part of the new Medication Management Plan. Each month, the medications on the MAR will be reconciled to the Medications stored for each resident and the current medication orders for each resident. The Owner will be responsible for this Corrective Action.	10/11/2024

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	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, clinical record review, and interview the facility failed to ensure a medication without a current physician order was not stored with a resident's active medications and included on the resident's Medication Administration Record (MAR) for 1 of 10 sampled residents (Resident #1). Findings include: Resident #1 Resident #1 was admitted to the facility on 12/11/2023, with diagnoses including dementia and chronic kidney disease. On 09/12/2024 at 10:26 AM, during a review of Resident #1's medications, the following medications were stored with Resident #1's active medications: -Albuterol Sulfate inhaler, 90 micrograms (mcg) per inhalation. - Symbicort inhaler, 160 mcg / 4.5 mcg. Resident #1's MAR included Albuterol inhaler 6.7, inhale one puff by mouth once as needed for wheezing. On 09/12/2024 at 12:00 PM, during an interview with the Manager and the Administrator, the Manager explained the facility did not have a current order onsite for the Albuterol Sulfate inhaler or the Symbicort inhaler. The Administrator confirmed all medications stored with a resident's active medications should have a physician's order. Severity: 2		This Corrective Action will be completed by11-12-2024.	

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	Scope: 1			
0885 SS= D	Medication - Destruction - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 9. If the medication of a resident is discontinued, the expiration date of the medication of a resident has passed, or a resident who has been discharged from the facility does not claim the medication, an employee of a residential facility shall destroy the medication, by an acceptable method of destruction, in the presence of a witness and note the destruction of the medication in the record maintained pursuant to NAC 449.2744. Inspector Comments: Based on observation, interview and record review the facility failed to ensure medications were destroyed for 1 of 10 sampled residents (Resident #7). Findings include: Resident #7 Resident #7 was admitted to the facility on 12/19/2018, with a diagnosis including dementia. On 09/12/2024 at 10:45 AM, during a review of Resident #7's medications, a bubble pack containing Quetiapine 25 milligrams (mg) tablets was with the resident's medications. The expiration date written on the bubble pack was June 2024. On 09/12/2024 at 10:50 AM, the Manager verbalized the facility had always referred to the expiration date on the typed medication label, not the handwritten expiration date on the bubble pack, and had not clarified why there were two expiration dates on the bubble pack. On 09/12/2024 at 10:52 AM, the Manager called the dispensing pharmacy and spoke with a Pharmacy Technician. The Pharmacy Technician explained the expiration date on the typed label referred to the expiration date of the physician's order and the handwritten expiration date on the bubble pack was the expiration date of the medication. The Pharmacy Technician confirmed the expiration date of June 2024 was the expiration date of the Quetiapine 25 mg tablets. Severity: 2 Scope: 1	0885	The medication in question had two different expiration dates shown on the label. One date showed that the medication had expired. The other date showed that it had not expired. The pharmacy that we use has changed their system so that their medications will be sent with only one expiration date on the label. In the future, if we receive any medications with two expiration dates on the label, we will call the pharmacy for clarification. The owner will be	10/11/2024

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			responsible for this corrective Action. This corrective action will be completed by11-12-2024.	

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0936 SS= D	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. Inspector Comments: Based on document review, clinical record review and interview, the facility failed to ensure 1 of 10 sampled residents met the requirements concerning tuberculosis (TB) testing in accordance with Nevada Administrative Code (NAC) 441A.375 (Resident #3). Findings include: Resident #3 Resident #3 was admitted to the facility on 03/25/2024, with diagnoses including essential hypertension, atrial fibrillation, and mild cognitive impairment. Resident #3's clinical record documented an initial 2-step TB test, with the first step given on 06/13/2022 and read negative on 06/15/2022. The second step was given on 06/20/2022 and read negative on 06/22/2022. Resident#3's clinical record documented an annual TB test given on 06/08/2023 and read negative on 06/10/2023. Resident #3's clinical record lacked documented evidence of a TB test for 2024. On 09/12/2024 at 9:22 AM, the Administrator confirmed Resident #3 lacked a TB test for 2024 and verbalized it was overlooked. Severity: 2 Scope: 1	0936	Resident #3had a blood sample taken for a QuantiFERON Gold TB Test on 09-10-2024. The results came back as negative on09-12-2024. The facility will test all residents and employees on an annual basis at the end of the year. The owner will be responsible for this corrective Action. This corrective action is already in place.	10/11/2024

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0950 SS= E	Hospice Care Responsibilities of Staff - NAC 449.275 Residential facility which provides residents with hospice care: Responsibilities of staff; retention of resident with special medical needs. (NRS 449.0302) 1. A residential facility that provides services to a resident who elects to receive hospice care shall obtain a copy of the plan of care required pursuant to NAC 449.0186 for that resident. Inspector Comments: Based on clinical record review and interview, the facility failed to ensure a hospice Plan of Care was obtained and retained by the facility for a resident receiving hospice care for 2 of 2 sampled hospice residents (Resident #2 and #3). Findings include: Resident #2 Resident #2 was admitted to the facility on 03/01/2024, with diagnoses including hydrocephalus and neuropathy. On 09/12/2024 at 10:23 AM, the Administrator confirmed Resident #2 was receiving hospice care from an outside agency and the facility did not have the resident's Plan of Care upon request from the State Survey Agency. Resident #3 Resident #3 was admitted to the facility on 03/25/2024, with diagnoses including essential hypertension, atrial fibrillation, and mild cognitive impairment. On 09/12/2024 at 9:22 AM, the Administrator confirmed Resident #2 was receiving hospice care from an outside agency and the facility did not have the resident's Plan of Care upon request from the State Survey Agency. Severity: 2 Scope: 2	0950	It will become the policy of this facility to maintain a Hospice Plan of Care in the Resident's chart. The Administrator will be responsible for this Corrective Action. This Corrective Action will be completed by 11-12-2024.	11/12/2024
1600 SS= C	Preferred Name/Pronoun P& P - Preferred Name/Pronoun P& P R016-20 Sec. 19 1. A facility shall: (a) Develop policies to ensure that a patient or resident is addressed by his or her preferred name and pronoun and in accordance with his or her gender identity or expression; and (b) Adapt electronic records and any paper records the facility has to reflect the gender identities or expressions of patients or residents with diverse gender identities or expressions, including, without limitation: (2) If the facility is a facility for the dependent or other residential facility, adapting electronic records and any paper records the facility	1600	The facility will develop a list of questions to be asked for each resident related to Preferred Name, Pronoun, Gender Identity or	11/12/2024

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	has to include the preferred name and pronoun and gender identity or expression of a resident. R016-20 Sec. 19 2. If a patient or resident chooses to provide the following information, the health records adapted pursuant to subparagraph (1) of paragraph (b) of subsection 1 must include, without limitation: (a) The preferred name and pronoun of the patient or resident; (b) The gender identity or expression of the patient or resident; (c) The gender identity or expression of the patient or resident that was assigned at the birth of the patient or resident; (d) The sexual orientation of the patient or resident; and (e) If the gender identity or expression of the patient or resident is different than the gender identity or expression of the patient or resident that was assigned at the birth of the patient or resident: (1) A history of the gender transition and current anatomy of the patient or resident; and (2) An organ inventory for the patient or resident which includes, without limitation, the organs: (I) Present or expected to be present at the birth of the patient or resident; (II) Hormonally enhanced or developed in the patient or resident; and (III) Surgically removed, enhanced, altered or constructed in the patient or resident. R016-20 Sec. 20 1. Except as otherwise provided in subsection 2, the statements, notices and information required by sections 2 to 22, inclusive, of this regulation and NRS 449.101 to 449.104, inclusive, must be in English and, as appropriate for a facility, in any other language the Department determines is appropriate based on the demographic characteristics of this State. In addition to the notices and information provided in English and any other language the Department determines is appropriate based on the demographic characteristics of this State, a facility may provide the statements, notices and information in any other language the facility may desire. R016 -20 Sec. 20 2. A facility must make reasonable accommodations in providing the statements, notices and information described in subsection 1 for patients or residents who: (a) Are unable to read; (b) Are blind or visually impaired; (c) Have communication impairments; or (d) Do not		expression, and Sexual Orientation. This information will be on the Face Sheet. The Face Sheet is used in multiple locations in the facility. The Owner will be responsible for this Corrective Action. This Corrective Action will be completed by 11-12-2024.	

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	read or speak English or any other language in which the statements, notices and information are written pursuant to subsection 1. Inspector Comments: Based on clinical record review and interview, the facility failed to ensure there were policies developed and resident records in compliance with Legislative Counsel Bureau File Number R016-20 Section 19, regarding resident records to reflect a resident's preferred name, pronoun, gender identity or expression, and sexual orientation for 10 of 10 sampled residents (Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, and #10), affecting 25 of 25 residents in the facility. Findings include: The following residents' records lacked the inclusion of a resident's choice to provide the resident's preferred name, pronoun, gender identity or expression, and sexual orientation: - Resident #1 was admitted to the facility on 12/11/2023, with diagnoses including Parkinson's disease and hypertension. - Resident #2 admitted to the facility on 03/01/2024, with diagnoses including hydrocephalus and neuropathy. - Resident #3 was admitted to the facility on 03/25/2024, with diagnoses including essential hypertension, atrial fibrillation, and mild cognitive impairment. - Resident #4 was admitted to the facility on 06/29/2024, with diagnoses including chronic obstructive pulmonary disease and type two diabetes mellitus without complications. - Resident #5 admitted to the facility on 06/08/2018, with diagnoses including dementia with behavioral disturbance and anxiety. - Resident #6 was admitted to the facility on 08/22/2024, with diagnoses including basal cell carcinoma, bipolar disorder and hepatitis C. - Resident #7 was admitted to the facility on 12/19/2018, with a diagnosis of dementia. - Resident #8 was admitted to the facility on 09/29/2017, with diagnoses including bipolar disorder, major depressive disorder, and fibromyalgia. - Resident #9 admitted to the facility on 02/16/2024, with diagnoses including incontinence, memory problem, and chronic systolic heart failure. - Resident #10 was admitted to the facility on 11/17/2023, with diagnoses including dementia without behavioral disturbance			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9070	A. BUILDING _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENDA CARE	1235 GLENDA WAY, RENO, NEVADA ,89509

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	and type II diabetes mellitus. On 09/12/2024 at 12:06 PM, the Administrator confirmed confirmed there were no changes to residents' clinical records in compliance with the regulation. Severity: 1 Scope: 3			
1800 SS= F	30 Day PPE Required - 30 Day PPE Required LCB File No. R048-22 Sec. 3 1. A medical facility, facility for the dependent or other facility required by the regulations adopted by the Board pursuant to NRS 449.0303 to be licensed shall ensure that each person on the premises of the facility uses personal protective equipment in accordance with the publications adopted by reference in section 2 of this regulation. The facility shall maintain: (a) Not less than a 30-day supply of personal protective equipment at all times; or (b) If the facility is unable to comply with the requirements of paragraph (a) due to a shortage in personal protective equipment, documentation of attempts by and the inability of the facility to obtain personal protective equipment. Inspector Comments: Based on observation and interview, the facility failed to maintain a 30-day supply of personnel protective equipment (PPE) onsite and available for use. Findings include: On 09/12/2024 at 12:15 PM, the facility's PPE supply was stored in the office closet. The closet contained approximately 120 masks, no face shields, and approximately 10 gowns. The facility had two of 25 residents with active COVID 19. Staff was entering and exiting the room housing the COVID positive residents without PPE and without using appropriate hand hygiene. On 09/12/2024 in the afternoon, the Administrator was unaware of the location of additional PPE. The Administrator confirmed the facility did not have a 30-day supply of PPE available and verbalized additional PPE was stored at other facilities. Severity: 2 Scope: 3	1800	The facility will Purchase and maintain a 30-day supply of PPE. The Administrator will be responsible for this Corrective Action. This Corrective Action will be completed by 11-12-2024.	11/12/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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1810 SS= C	Infection Control Program - Infection Control Program LCB File No. R048-22 Sec. 5 1. A facility for the dependent shall: (a) Develop and carry out an infection control program to prevent and control infections within the facility; (b) Review the infection control program, including, without limitation, the infection control policy adopted pursuant to subsection 2, at least annually to ensure that the program meets current evidence-based standards for infection control plans and the safety needs of residents, staff and visitors; Inspector Comments: Based on document review and interview, the Administrator failed to ensure the facility's Infection Control Program was reviewed annually. On 09/12/2024 at 12:00 PM, the facility's Infection Prevention and Control Plan, dated 12/31/2020, was provided by the Administrator. The Infection Prevention and Control Plan lacked documented evidence the plan was reviewed annually. On 09/12/2024 at 12:25 PM, the Administrator confirmed the facility's Infection Prevention and Control Plan was not reviewed annually. Severity: 1 Scope: 3	1810	The facility is in the process of updating the Infection Prevention and Control Plan. The Owner is responsible for this Corrective Action. This Corrective Action will be completed by 11-12-2024.	11/12/2024