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 _____	**07/28/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENDA CARE	**1235 GLENDA WAY, 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
0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a State Licensure annual grading survey and a Complaint Investigation conducted at your facility on 07/28/205. 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 24. There were two Complaints investigated. The sample size was ten residents and ten employees. The facility received a grade of B. CPT #NV00074253 with an allegation the facility initiated an unsafe and inappropriate discharge of a resident could not be substantiated due to a lack of evidence. The investigation into the allegation included: Observations of residents in rooms, residents in common areas, and a tour of the facility. Interviews were conducted with the Administrator and the Manager. Record review included face sheets, physician orders, service plans, Admission Agreements, acute care hospital progress notes, and Client History Sheets. Document review included Policy of Admission. Complaint #NV00074302 with the following allegations could not be substantiated due to lack of evidence. Allegation #1, a resident was left in wet briefs from 6:00 PM until 9:30 AM the following morning. Allegation #2, a resident did not have a call button in the resident's room and was unable to call for assistance. Allegation #3, a resident's medication administration record (MAR) contained medication discrepancies. Allegation #4, a resident's service plan was incomplete. The investigation into the allegations included: Observation of grooming and physical appearance for residents, call buttons in resident bedrooms and bathrooms, and a	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: SCOTT REDDY Title: Administrator Date: 08/15/2025

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**07/28/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENDA CARE	**1235 GLENDA WAY, 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
	tour of the facility. Interviews were conducted with residents, a Caregiver/Medication Technician, and an Owner. Record review of four current resident records and one closed record, including the resident of concern, included review of MARs, medication orders, history and physicals, activity of daily living assessments, Physician Placement Determinations, and the person centered plan of care. 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:			
0826 SS= D	Tracheostomy or Open Wound - NAC 449.2734 Residents having tracheostomy or open wound requiring treatment by medical professional; residents having pressure or stasis ulcers. (NRS 449.0302) 3. The administrator of the facility shall ensure that records of the care provided to a person who has a pressure or stasis ulcer pursuant to subsection 2 are maintained at the facility. The records must include an explanation of the cause of the pressure or stasis ulcer. Inspector Comments: Based on interview and record review, the Administrator failed to ensure records of the care provided to a person who has a pressure or stasis ulcer were on-site and available for a resident with a pressure ulcer (Resident #6). Resident #6 Resident #6 was admitted on 07/01/2025, with diagnoses including chronic leg wounds and hypertension. On 07/28/2025 at 11:27 AM, the Manager verbalized upon entry into the facility Resident #6 was the only resident in the facility with a pressure injury. The Manager explained Home Health came into the facility, unsure how often, each week to manage Resident #6's wounds. The	0826	The surveyor’sfindings are correct. The Administratorobtained the Home Health Plan of Care on 07-29-2025, the day after the Surveyby asking for it from the Home Health agency. It willbecome the practice of the facility to request the Home	08/15/2025

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 _____	**07/28/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENDA CARE	**1235 GLENDA WAY, 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
	Manager confirmed there was no documented evidence of wound care for Resident #6. Severity: 2 Scope: 1		Health Plan of Careupon admission of a resident requiring Home Health Services of a scoperequiring a Waiver from HCQC. Theadministrator will be responsible for this change. This change is already in place.	
0835 SS= D	Exemption Requests - NAC 449.2736 Procedure to exempt certain residents from restrictions. (NRS 449.0302) 3. A written request submitted to the Division pursuant to this section must be received: (a) Before the administrator admits a resident; or (b) At the onset of a medical condition set forth in NAC 449.271 to 449.2734, inclusive. Inspector Comments: Based on interview, clinical record review, and observation, the facility failed to obtain an exemption request to retain a resident who had wounds for 1 of 10 sampled residents (Resident #6). Findings include: Resident #6 Resident #6 was admitted to the facility on 07/01/2025, with a diagnosis of chronic leg wounds. Resident #6's facility Plan of care, documented Resident #6 received skilled nursing services for leg wounds. On 07/28/2025 at 11:27 AM, the Owner confirmed Resident #6 received wound care from a Home Health agency. The Owner	0835	Thesurveyor's findings are correct. TheAdministrator obtained the Home Health Plan of Care on 07-29-2025, the dayafter the Survey by asking for it from the Home Health agency. The Administrator then	08/15/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**07/28/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENDA CARE	**1235 GLENDA WAY, 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
	admitted the facility did not submit an exemption request for wounds to admit and retain Resident #6. Severity: 2 Scope: 1		applied for the HomeHealth Waiver and the Home Health Waiver was received by the facility 07-30-2025. It willbecome the practice of the facility to request the Home Health Plan of Care priorto, or upon, admission of a resident requiring Home Health Services of a scoperequiring a Waiver from HCQC. This hasbeen added to the Admission Checklist. The administrator will be responsible forthis change. This change	

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 _____	**07/28/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENDA CARE	**1235 GLENDA WAY, 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
			is already inplace.	
0874 SS= E	Medication Administration-Report Received - NAC 449.2742 and R043-22 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 2. Within 72 hours after the administrator of the facility receives a report submitted pursuant to paragraph (a) of subsection 1, a member of the staff of the facility shall notify the resident's physician, physician assistant or advanced practice registered nurse of any concerns noted by the person who submitted the report. The report must be reviewed and initialed by the administrator. Inspector Comments: Based on clinical document review, record review, and interview, the Administrator failed to ensure a medication profile review, performed by a physician, pharmacist, or registered nurse at least once every six months with recommendation from the six month medication profile review was forwarded to the resident's provider within 72 hours for 3 of 10 sampled residents reviewed for medications and residing in the facility longer than six months (Resident#3, #9 , and #5). Findings include: Medication Profile Review dated June 2025 The following residents' six month medication profile review lacked the facility's notification to the resident's provider of a medication review recommendation within 72 hours: - Resident #3 was admitted to the facility on 11/02/2022, with a diagnoses including cognitive impairment, and hypothyroidism. - Resident #9 was admitted to the facility on 06/08/2024, with diagnoses including hypertension, depression and chronic pain. On 07/28/2025 at 10:32 AM, the Administrator and Manager confirmed the Medication Reviews for Resident #3 and Resident #9 included suggested monitoring	0874	TheAdministrator misinterpreted the regulation. The Medication Review form in question lists: Identified medication issues, and Suggestedmonitoring/ changes. The regulationsspecifies “Concerns” The Administratordid not consider Suggested monitoring/changes as the same as concerns. It willbecome the practice of the facility to make sure that any concerns, whether	08/15/2025

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 _____	**07/28/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENDA CARE	**1235 GLENDA WAY, 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
	and denied the facility had documentation the residents' Physician was notified of the suggestions. Resident #5 Resident #5 was admitted to the facility on 09/09/2024, with diagnoses including dementia, diabetes, and hypertension. Resident #5's record included a Medication Review dated 06/01/2025. The Medication Review included suggestions to monitor respiratory rate, electrocardiogram (ECG), and blood pressure. The Medication Review was signed by the Pharmacist and the Administrator. The form lacked a signature from the Physician and any documentation the Physician was notified of the suggestions. On 07/28/2025 at 11:40 AM, the Administrator confirmed the Medication Review for Resident #5 included suggested monitoring and denied the facility had documentation the resident's Physician was notified of the suggestions. Severity: 2 Scope: 2		Identifiedmedication issues or Suggested monitoring/changes, are reported to theresident’s physicians within 72 hours of receiving a medication review with anypossible concerns noted on the Medication Review. The Administrator will be responsible forthis correction. The correction isalready complete.	
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	0878	It has beenthe policy to place red stickers on the medication container advising of medicationchanges, if	08/15/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**07/28/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENDA CARE	**1235 GLENDA WAY, 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
	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 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		there has been a medication order change, but we had run out ofstickers. The Administrator has printedsome new red stickers that say, “Medication Change please see MAR.” TheMedication Technician has been instructed to ask for more stickers when theyrun low. The Administrator will beresponsible for this correction. The correctionis already complete.	

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 _____	**07/28/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENDA CARE	**1235 GLENDA WAY, 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
	observation, interview, and record review the facility failed to ensure a medication in use had a change label placed on the medications label when the medication's frequency was changed by a physician's order for 1 of 10 sampled residents (Resident #8). Findings include: Resident #8 Resident #8 was admitted to the facility on 02/26/2024, with diagnoses including memory problems and cerebral atherosclerosis. On 07/28/2025 at 10:15 AM, during a review of Resident #8's medications, the following was observed: - a bottle of morphine sulfate 100 milligrams (mg)/5 milliliters (ml) with the instructions to take 0.25 ml by mouth every four hours as needed for pain or shortness of breath documented on the medication's label. - the July 2025 Medication Administration Record (MAR) documented morphine sulfate 100 mg/5 ml take 0.25 ml by mouth every two hours as needed for pain or shortness of breath. The order for Resident #8's morphine sulfate, dated 02/26/2024, documented the following: - morphine sulfate 100 mg/5 ml, take 0.25 ml by mouth every 2 hours as needed for pain or shortness of breath. On 07/28/2025 at 10:18 AM, the Owner confirmed the MAR and order did not match the instructions on the medication label for the morphine sulfate and the medication label should have had a change label. Severity: 2 Scope: 1			

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 _____	**07/28/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENDA CARE	**1235 GLENDA WAY, 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
1011 SS= E	Care for Persons with Mental Illnesses - NAC 449.2764 Residential facility which offers or provides care for persons with mental illnesses: Application for endorsement; training for employees. (NRS 449.0302) 2. A person who provides care for a resident of a residential facility for persons with mental illnesses shall, within 60 days after becoming employed at the facility, attend not less than 8 hours of training concerning care for residents who are suffering from mental illnesses. Inspector Comments: Based on personnel record review, document review, and interview, the facility failed to ensure 3 of 10 sampled employees working at the facility greater than 60 days and less than one year received eight hours of initial training to care for residents with a mental illness, within 60 days of hire (Employee #5, #7, and #8). Findings include: On 07/28/2025 in the morning, personnel records were reviewed at the facility. The following was discovered: Employee #5 Employee #5 was hired by the facility as a Med Tech/ Caregiver with a start date of 03/30/2025. Employee #5's personnel file had no record of mental illness training. Employee #7 Employee #7 was hired by the facility as a Caregiver/Cleaner with a start date of 11/14/2024. Employee #7's personnel file had no record of mental illness training. Employee #8 Employee #8 was hired by the facility as a Cook/Cleaner with a start date of 05/16/2025. Employee #8's personnel file had no record of mental illness training. On 07/28/2025 at 12:03 PM, the Manager confirmed Employee #5, #7, and #8 lacked the 8 hours of mental illness training within 60 days of hire. Severity: 2 Scope: 2	1011	TheFacility will contract with Relias.com to provide training and to keep track oftraining for most of our training needs including the training required for theMental Health Endorsement and other training issue. The Administrator is responsible for thiscorrection. This correction will becompleted by 09-15-2025.	09/15/2025
1700 SS= D	Annual Assessment of History of Each Resident - NRS 449.1845 Administrator of residential facility for groups to conduct annual assessment of history of each resident and cause provider of health care to conduct certain examinations and	1700	TheAdministrator misinterpreted the	08/15/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**07/28/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENDA CARE	**1235 GLENDA WAY, 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
	assessments; placement based on assessment. 1. The administrator of a residential facility for groups shall: (a) Annually cause a qualified provider of health care to conduct a physical examination of each resident of the facility; (b) Annually conduct an assessment of the history of each resident of the facility, which must include, without limitation, an assessment of the condition and daily activities of the resident during the immediately preceding year; and (c) Cause a qualified provider of health care to conduct an assessment of the condition and needs of a resident of the facility to determine whether the resident meets the criteria prescribed in paragraph (a) of subsection 2: (1) Upon admission of the resident to the facility; and (2) If a physical examination, assessment of the history of the resident or the observations of the administrator or staff of the facility, the family of the resident or another person who has a relationship with the resident indicate that: (I) The resident may meet those criteria; or (II) The condition of the resident has significantly changed. 2. If, as a result of an assessment conducted pursuant to paragraph (c) of subsection 1, the provider of health care determines that the resident: (a) Suffers from dementia to an extent that the resident may be a danger to himself or herself or others if the resident is not placed in a secure unit or a facility that assigns not less than one staff member for every six residents, any residential facility for groups in which the resident is placed must meet the requirements prescribed by the Board pursuant to subsection 2 of NRS 449.0302 for the licensing and operation of residential facilities for groups which provide care to persons with Alzheimer's disease or other severe dementia. (b) Does not suffer from dementia as described in paragraph (a), the resident may be placed in any residential facility for groups. 3. As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031. (Added to		regulation. Based on previous annual surveys, the Administrator believed that theStandard Physician's Assessment was only required if a resident had a diagnosisof "Alzheimer's or Related Dementia." Theresident in question does not have a diagnosis of dementia. It willbecome the practice of the facility to make sure that all residents admitted tothe facility have the Standard Physician's Assessment before	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**07/28/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENDA CARE	**1235 GLENDA WAY, 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
	NRS by 2019, 2594) Inspector Comments: Based on record review and interview, the Administrator failed to ensure an initial Physician Placement Determination was completed prior to admitting 1 of 10 residents to the facility (Resident #6). Findings include: Resident #6 Resident #6 was admitted to the facility on 07/01/2025, with diagnoses including hypertension, and chronic leg wounds. Resident #6's record lacked documented evidence a Physician Placement Determination was completed on upon admission to the facility. On 07/28/2025 at 11:20 AM, the Manager confirmed the Physician Placement Determination for Resident #6 was not completed upon the resident admitting into the facility. The Manager verbalized the not knowing Physician Placement Determination needed to be completed for a resident not having a dementia/Alzheimer's diagnosis. Severity : 2 Scope : 1		they can be admittedto the facility. The Administrator willbe responsible for this correction. Thecorrection is already complete.	
1825 SS= D	Designation/Training persons for IC Program - NAC 449.0109 Designation and training of person responsible for infection control. 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. 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	1825	The Facilitywill contract with Relias.com to provide training and to keep track of trainingfor most of our training needs including the training required for InfectionControl and other training issue.	09/15/2025

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 _____	**07/28/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENDA CARE	**1235 GLENDA WAY, 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
	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. Inspector Comments: Based on personnel record review and interview, the facility failed to ensure the secondary employee responsible for infection control (Employee #3) completed 15 hours of training related to the control and prevention of infections from an approved organization. Findings include: Employee #3 Employee #3 was hired on 02/02/2018, as a Caregiver/Cook. Employee #3 was designated as the secondary employee responsible for infection control in the facility. Employee #3's personnel record lacked documented evidence of 15 hours of infection control and prevention training from an approved organization. On 07/28/2025 in at 12:05 PM, the Administrator verbalized Employee #3 did not complete the 15 hours of infection prevention and control training through an approved organization. Severity: 2 Scope: 1		TheAdministrator is responsible for this correction. This correction will be completed by09-15-2025.	