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
	1884	A. BUILDING _____ B. WING _____	03/18/2025

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

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a State Licensure grading resurvey conducted at your facility on 03/18/2025. This survey was conducted by the Division of Public and Behavioral Health in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 56 Residential Facility for Group beds, with assisted living services for elderly or disabled persons, and/or persons with Alzheimer's disease, Category II residents. The census at the time of the survey was 51. Fifteen resident files were reviewed, and fifteen employee files were reviewed. The facility received a grade of D. NAC 449.27706 Resurvey: Application and fee; failure to comply. 2. If the Bureau issues a placard to a residential facility that includes a grade of "C" or "D," the administrator must submit an application to the Bureau for a resurvey of the facility not later than 30 days after the facility receives the placard. The fee for an application for a resurvey is $600 and must accompany the application. 3. The Bureau may revoke the license of a residential facility that is required to submit an application for a resurvey pursuant to subsection 2 if the facility fails to submit the application in accordance with the provisions of that subsection. 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:	0000		

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0255 SS= F	Permits-Comply with NAC 446 on Food Service - NAC 449.217 Kitchens; storage of food; adequate supplies of food; permits; inspections. (NRS 449.0302) 6. A residential facility with more than 10 residents shall: (a) Comply with the standards prescribed in chapter 446 of NAC; and (b) Obtain the necessary permits from the Division. Inspector Comments: Based on observation on 3/18/25, the facility failed to ensure the kitchen and supportive dining services complied with the standards of NAC 446. Findings include: 1. Critical Violations: a. The Garden, Boat, and Cottage serving kitchen dishwashing machine final rinse cycles were not sanitizing at the time of inspection. No detectable chlorine was observed at each machine. Further investigation revealed each dishwashing machine was not being monitored and had empty sanitizer solution containers. In addition to the empty chlorine containers, containers for the wash and rinse detergents were either empty, not connected, or the plastic dispensing lines were obstructed. 2. Major Violations: a. The main kitchen ice machine had excessive biofilm buildup near the interior ice cube maker. b. The interior surfaces of the reach-in refrigerators located in Garden, Boat, Country and Cottage were soiled with liquid and solid food debris. c. The Garden, Boat, Country and Cottage serving kitchen floors were heavily soiled with food debris under and behind kitchen equipment. Severity: 2 Scope: 3	0255	1. To correct finding, dishwashing machines have been refilled with appropriate sanitizing solutions including chlorine and tested to ensure that dispensing lines are working properly. Main kitchen ice machine has been cleaned. Interior surfaces of the reach in refrigerators located in Garden, Boat, Country, and Cottage have been cleaned and kitchen floors have been cleaned in addition to areas under and behind kitchen equipment. 2. Measures to ensure compliance includes weekly monitoring of dishwashing machines, scheduled cleaning log for the ice machine and daily inspection of cleanliness in each serving kitchen. 3. Monitoring will include a weekly log for the dishwashing machines, a cleaning schedule for the ice machine and a daily task list checklist for cleanliness for each shift. 4. Dining Service Manager will be responsible to maintain the weekly log for each dishwasher and the cleaning schedule for the ice machine. Each shift lead will be responsible for the cleanliness of each serving kitchen area and report to the Health and Wellness Director of findings. 5. Correction of implementation will begin 6/30/25	06/30/2025
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	0515	1.To correct findings, audit completed by interim Health and Wellness director and Executive Director completed on 6/30/25 to verify appropriate signatures are in place on Service Plans. Corrections made where indicated. 2. Health and Wellness Director and Executive Director will review service plan policy audit resident	06/30/2025

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	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 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 15 of 15 sampled residents reviewed for service plans (Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, and #15). Findings include: The following residents' person-center service plans lacked documented evidence the facility had met with the resident and/or the resident's family or representative to develop their service plan: - Resident #1 was admitted to the facility on 02/06/2025, with diagnoses including dementia, mild, with agitation, major depressive disorder, and Alzheimer's disease with late onset. - Resident #2 was admitted to the facility on 09/05/2024, with diagnoses including dementia with behavioral disturbances, history of transient ischemic attack, and type II diabetes mellitus. - Resident #3 was admitted to the facility on 10/24/2024, with diagnoses including dementia, mild, with anxiety, cardiac pacemaker, and malignant neoplasm of kidney. - Resident #4 was admitted to the facility on 08/15/2019, with diagnoses including dementia, arthritis, and anemia. - Resident #5 was admitted to the facility on 02/28/2025, with diagnoses including dementia, hyperlipidemia, and hypertension. - Resident #6 was admitted to the facility on 03/04/2025, with diagnoses including dementia, coronary artery disease, and stroke. - Resident #7 was admitted to the facility on 02/19/2025, with diagnoses including dementia, hyperlipidemia, and asthma. - Resident #8 was admitted to the facility on 10/13/2023, with diagnoses including Parkinson's disease, dementia, hypertension, hypothyroidism, and macular degeneration. - Resident #9 was admitted to the facility on 01/29/2025, with diagnoses including Alzheimer's disease, depression, and chronic embolism and thrombosis of deep		charts to ensure compliance. Care Conference will be scheduled with responsible parties to have service plan reviewed and signed. 3. Corrective action will be monitored by scheduling a weekly meeting between ED and HWD for 4 weeks. 4. Health and Wellness Director or Designee will be responsible for documenting the completion of Service plan review/Care Conference and collaborative efforts in Point Click Care. 5. Correction has been implemented on 6/30/25.	

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	veins of lower extremity. - Resident #10 was admitted to the facility on 11/26/2024, with diagnoses including dementia with behavioral disturbances and major depressive disorder. - Resident #11 was admitted to the facility on 01/03/2020, with diagnoses including vascular dementia, hypertension, and depression. - Resident #12 was admitted to the facility on 10/25/2023, with diagnoses including dementia without behavioral disturbances and hypertension. - Resident #13 was admitted to the facility on 09/10/2024, with diagnoses including Alzheimer's dementia, major depressive disorder, and hypothyroidism. - Resident #14 was admitted to the facility on 09/06/2024, with diagnoses including dementia-moderate, depression, and epilepsy. - Resident #15 was admitted to the facility on 11/09/2024, with diagnoses including dementia, hypertension, hypothyroidism, and coronary artery disease. On 03/18/2025 at 12:36 PM, the Health and Wellness Director (HWD) confirmed the HWD did not have documentation of meeting and collaborating with the residents and/or resident's family or representative to develop the resident's service plan for Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, and #15. A facility policy titled "Service Plan Process Policy," last revised 03/2020, documented the service plan should be completed and reviewed by the facility and the resident/legally responsible party. Severity: 2 Scope: 3			

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0644 SS= C	Posting Requirements - 1. A person who operates a residential facility for groups shall: (a)?Post his or her license to operate the residential facility for groups; (b)?Post the rates for services provided by the residential facility for groups; and (c)?Post contact information for the administrator and the designated representative of the owner or operator of the facility, in a conspicuous place in the residential facility for groups. Inspector Comments: Based on observation and interview, the facility failed to post the Administrator's designee with contact information and the facility rates in a conspicuous place in the facility. Findings include: On 03/18/2025 at 12:49 PM, the Administrator's designee with contact information were not posted in a conspicuous place in the facility. On 03/18/2025 at 12:49 PM, the Health and Wellness Director confirmed the Administrator's designee and contact information were not posted. On 03/18/2025 at 12:49 PM, the facility rates were not posted in a conspicuous place in the facility. On 03/18/2025 at 12:49 PM, the Sales Manager confirmed the facility rates were not posted. Severity: 1 Scope: 3	0644	1. To correct findings, Administrator's designee with contact information and facility rates will be posted in front lobby. 2. Information will be posted and added to items included in front lobby bulletin board for permits, license and other items needed to be posted in a conspicuous place. Front desk staff to be informed of posting so as to update information as needed. 3. Correction will be monitored by daily visual inspection. Monthly check of postings will be conducted to verify information is up to date. 4. Executive Director or designee will be responsible to confirm correction. Front desk staff will also be informed in order to support compliance. 5. Correction implemented 3/20/25.	03/20/2025

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0859 SS= D	Medical Care of Resident After Illness - NAC 449.274 and R043-22 Medical care of resident after illness, injury or accident; periodic physical examination of resident; rejection of medical care by resident; written records. (NRS 449.0302) 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by a qualified provider of health care in accordance with NRS 449.1845. The resident must be cared for pursuant to any instructions provided by the qualified provider of health care. Inspector Comments: Based on record review and interview, the facility failed to ensure a physical examination was completed annually for 1 of 15 residents (Resident #11). Findings include: Resident #11 Resident #11 was admitted to the facility on 01/03/2020, with diagnoses including vascular dementia, hypertension, and depression. Resident #11's clinical record lacked documented evidence of an annual physical examination with a review of systems for 2024. On 03/18/2025 at 2:25 PM, the Wellness Director confirmed the missing physical examinations and was unable to provide documented evidence of a physical examination completed for Resident #11. Severity: 2 Scope: 1	0859	1. Missing physical examination to be completed by healthcare provider. 2. PPOC will be completed for each resident by their medical doctor prior to moving in to the community and general physical examination will be conducted by a qualified healthcare provider. 3. PPOC will be updated annually or when resident has change of condition. 4. The Health and Wellness Director will be responsible for ensuring compliance. 5. Implementation of correction began on 6/15/25 and is ongoing.	06/15/2025
0874 SS= F	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	0874	1. Correction involves initialing medication review and documenting that recommendations are forwarded to healthcare provider. 2. Collaboration and scheduling of medication reviews between leadership and physician, pharmacist, or APRN will occur to verify that review is received, reviewed, and acknowledged by initials and recommendations are forwarded to healthcare provider. Collaboration will include scheduling review so that review is given to appropriate party within 72 hours. 3. Reviews will be scheduled and posted ahead of time so that appropriate parties are present	05/03/2025

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	a medication profile review, performed by a physician, pharmacist, or registered nurse at least once every six months, 1) was reviewed and initialed by the Administrator within 72 hours for 5 of 5 sampled residents residing in the facility for longer than six months (Resident #2, #4, #8, #11, and #12), and 2) the recommendation from the six month medication profile review was forwarded to the resident's provider within 72 hours for 7 of 7 sampled residents reviewed for medications and residing in the facility longer than six months (Resident #2, #4, #8, #11 #12, #13, and #14). Findings include: Medication Profile Review dated April 2024 The following residents' six month medication profile review lacked the Administrator's review and initials within 72 hours: - Resident #2 was admitted to the facility on 09/05/2024 with a diagnoses of dementia with behavioral disturbances. - Resident #4 was admitted to the facility on 08/15/2019, with diagnoses including dementia, arthritis, and anemia. - Resident #8 was admitted to the facility on 10/13/2023, with diagnoses including Parkinson's disease, dementia, hypertension, hypothyroidism, and macular degeneration. - Resident #11 was admitted to the facility on 01/03/2020, with diagnoses including vascular dementia, hypertension, and depression. - Resident #12 was admitted to the facility on 10/25/2023, with diagnoses including dementia without behavioral disturbances and hypertension. Medication Profile Review dated October 2024 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 #2 was admitted to the facility on 09/05/2024 with a diagnoses of dementia with behavioral disturbances. - Resident #4 was admitted to the facility on 08/15/2019, with diagnoses including dementia, arthritis, and anemia. - Resident #8 was admitted to the facility on 10/13/2023, with diagnoses including Parkinson's disease, dementia, hypertension, hypothyroidism, and macular degeneration. - Resident #11 was admitted to the facility on 01/03/2020, with diagnoses including vascular dementia, hypertension,		after review. Reviews will be initialed and forwarded to healthcare providers. 4. Health and Wellness Director and Executive Director will be responsible to support compliance. 5. Correction was done on 5/3/25.	

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	and depression. - Resident #12 was admitted to the facility on 10/25/2023, with diagnoses including dementia without behavioral disturbances and hypertension. - Resident #13 was admitted to the facility on 09/10/2024, with diagnoses including Alzheimer's dementia, major depressive disorder, and hypothyroidism. - Resident #14 was admitted to the facility on 09/06/2024, with diagnoses including dementia-moderate, depression, and epilepsy. On 03/18/2025 at 2:19 PM, the Health and Wellness Director confirmed the six month medication review findings and verbalized the medication profile reviews conducted in April 2024 were not was reviewed and initialed by the Administrator within 72 hours for Resident #2, #4, #8, #11, and #12, and the recommendation from the six month medication profile review in October 2024 was forwarded to the resident's provider within 72 hours for Resident #2, #4, #8, #11 #12, #13, and #14. 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	0878	1. Medication will be administered as prescribed. Any orders changed by the physician will require a change label added to the medication, and medications will be available on site to be administered as prescribed. 2. Medication technician assisting and administering the medication will check the label 3 times to verify the medication is correct. Wellness Director or designee is responsible for obtaining new order of medication, change in instruction or medication discontinue orders. 3. Each resident must have an eMAR to document after a medication is received by the resident, the individual administering will document that medication was "administered" in system. If medication in not given, refused, not available, then individual will document the appropriate action, and primary care provider will be contacted. Medications stored by the community will be stored in designated	06/30/2025

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	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 record review, observation, and interview, the facility failed to ensure 1) medication was administered as prescribed for 2 of 15 sampled residents (Resident #12 and #4), 2) medication in use was correct and a change label was placed on a medication when changed by a physician's order for 1 of 15 residents (Resident #2), and 3) a medication was available on site to administer as prescribed for 1 of 15 sampled residents (Resident #12). Findings include: Medication Not Available Resident #12's physician order dated 01/25/2024, documented Lisinopril 10 milligram (mg) tab, take one tablet by mouth every day for essential hypertension. Resident #12's MAR documented the medication/treatment was not available/pharmacy action for 03/17/2025 and 03/18/2025. On 03/18/2025 at 1:46 PM, during a review of Resident #12's medications, the Lisinopril 10 mg was not located in the medication cart. The MT		locations, must be locked when unused or unattended. HWD and ED will audit3 rooms a week for a period of 8 weeks to verify ongoing compliance 4. Health and Wellness Director will be responsible for compliance. 5. Correction implementation is on going as of 6/30/25	

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	confirmed the refill had been called into the pharmacy on 03/17/2025, however the medication had not yet arrived and the resident had missed doses on 03/17/2025 and 03/18/2025. The MT was unsure if the medication would arrive in time for the morning dose on 03/19/2025. Medication Administration Resident #12 Resident #12 was admitted to the facility on 10/25/2023, with diagnoses including dementia without behavioral disturbances, hypertension, anxiety and major depressive disorder. Resident #12's Medication Administration Record (MAR) documented the following: -Atorvastatin Calcium oral tablet 80 mg, give one tablet in the evening for hyperlipidemia -Trazadone hydrochloride (HCl) oral tablet 50 mg, give one tablet at bedtime for insomnia. -Buspirone HCl oral tablet 15 mg, give two times a day related to anxiety. -Memantine HCl oral tablet 10 mg, give two times a day related to dementia. Resident #12's MAR lacked documentation the following medications were administered for the following dates: -Atorvastatin 80 mg: 03/08/2025 and 03/16/2025. -Trazadone 50 mg: 03/03/2025, 03/08/2025, 03/13/2025, and 03/16/2025. -Buspirone 15 mg: 03/16/2025, evening dose. -Memantine 10 mg: 03/08/2025 and 03/16/2025. On 03/18/2025 at 1:41 PM, a Medication Technician (MT) explained blank areas on the resident's MAR indicated the medication was not given and should have a code indicating a reason. The MT confirmed the blank areas on the MAR for the Atorvastatin, Trazadone, Buspirone, and Memantine and there was no documented reason why the medications were not administered. The facility policy titled "PL.6-041 Medication Administration," revised 03/2025, documented the associate would document the refusal or reason for not administering medication as ordered. Medication Order Resident #2 Resident #2 was admitted to the facility on 09/05/2024, with diagnoses including dementia with behavioral disturbances, history of transient ischemic attack, and type II diabetes mellitus. A physician's order dated 12/06/2024, documented Diclofenac 50 mg, take one table by mouth every other day. A physician's order dated 01/31/2025,			

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	documented Diclofenac 50 mg, take one table by mouth every day. Resident #2's March 2025 Medication Administration Record documented Dicflonec Potassium Oral Tablet 50 mg, take one tablet every other day related to dementia. Resident #2's medication, in the medication cart, documented Dicflonec Sodium Oral Tablet 50 mg, take one tablet every other day related to dementia. On 03/18/2025 at 1;15 PM, the Health And Wellness Director confirmed the administration of the Dicflonec Sodium medication for Resident #2 needed to be verified with the physician and the medication needed a change label for the change in the frequency of the medication. Medication Administration Resident #4 Resident #4 was admitted to the facility on 08/15/2019, with diagnoses including dementia, arthritis, and anemia. Resident #4's March 2025 MAR documented the following: -Quetiapine Fumarate Oral Tablet 50 mg, Give one tablet by mouth at bedtime for unspecified dementia. Resident #4's MAR lacked documentation the following medications were administered for the following dates: -Quetiapine Fumarate Oral Tablet 50 mg: 03/03/2025, 03/08/2025, 03/13/2025, and 03/16/2025. Severity: 2 Scope: 1			

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	1884	A. BUILDING _____ B. WING _____	03/18/2025

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0920 SS= F	Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 1. Medication, including, without limitation, any over-the-counter medication, stored at a residential facility must be stored in a locked area that is cool and dry. The caregivers employed by the facility shall ensure that any medication or medical or diagnostic equipment that may be misused or appropriated by a resident or any other unauthorized person is protected. Medications for external use only must be kept in a locked area separate from other medications. A resident who is capable of administering medication to himself or herself without supervision may keep the resident ' s medication in his or her room if the medication is kept in a locked container for which the facility has been provided a key. 2. Medication stored in a refrigerator, including, without limitation, any over-the-counter medication, must be kept in a locked box unless the refrigerator is locked or is located in a locked room. Inspector Comments: Based on observation, document review, and interview, the facility failed to ensure resident medications were kept secured in the facility for 51 of 51 residents. Findings include: On 03/18/2025 at 9:39 AM through 9:49 AM, the following resident rooms contained unsecured medications: - At 9:39 AM, in Room 35, 25 eight-ounce containers of Ensure were unsecured in the resident's room. - At 9:49 AM, in Room 37, a seven-day pill container with unknown pills in the compartments and a box of Exlax were unsecured in the resident's room. On 03/18/2025 at 9:39 AM through 9:49 AM, the Health and Wellness Director confirmed the medications should be secured. Severity: 2 Scope: 3	0920	1. Correction of deficiency includes removal of medication in resident rooms and inspection of resident room. 2.Reeducation provided to residents who self administer medication and associates provided on 7/10/25 by ED and HWD on medication storage and access. 3. Monitoring of compliance will include ED or HWD auditing 3 rooms a week for a period of 8 weeks to verify ongoing compliance 4. ED will be responsible for compliance. 5. Implementation of correction is as of 6/30/25.	06/30/2025
0999 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 and R043-22 Residential facility which provides care to persons with Alzheimer ' s disease: Standards for safety; personnel required; training for employees. (NRS 449.0302) 1. The administrator of a residential facility which provides care to persons with Alzheimer ' s disease or other	0999	1. To correct finding, toxic items will be made inaccessible to residents. 2. Toxic items in resident rooms and public areas will be stored in a locked cabinet or area. Improved	06/29/2025

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	forms of dementia who meet the criteria prescribed in paragraph (a) of subsection 2 of NRS 449.1845 shall ensure that: (g) All toxic substances are not accessible to the residents of the facility. Inspector Comments: Based on observation and interview, the facility failed to ensure toxic items were inaccessible to residents for 51 of 51 residents. Findings include: On 03/18/2025 at 9:41 AM through 11:21 AM, the following toxic items were discovered in the facility: - At 9:41 AM, in Room 37, an eleven-ounce can of Raid insect killer and a 5.1-ounce tube of Colgate toothpaste were unsecured in the resident's room. - At 9:49 AM, in Room 34, a 7.5-ounce container of Kroger Ripe Melon Antibacterial soap, a six-ounce tube of Colgate Sensitive toothpaste, and a bar of soap were unsecured in the resident's room. - At 9:53 AM, in Room 32, a 1.5-ounce container of Sparkle toothpaste was unsecured in the resident's room. - At 9:55 AM, in Room 30, a container of petroleum jelly and a tube of Colgate toothpaste were unsecured in the resident's room. - At 10:06 AM, in Room 41, a 5.1-ounce tube of Crest Pro Health, an 18-ounce container of Act Anticavity mouth wash, two seven-ounce cans of Gillette Series shave gel, a 16-ounce container of Lubriderm Daily Moisture lotion, a four-ounce container of CVS foot cream, a two-ounce container of Neutrogena hand cream, and a bar of soap were unsecured in the resident's room. - At 10:11 AM, in the Boathouse kitchen, dishwasher detergent was unsecured in a lower cabinet. - At 10:18 AM, in Room 51, a 16.9-ounce container of Nivea Maximum Hydration and a 6.4-ounce tube of Colgate toothpaste were unsecured in the resident's room. - At 10:20 AM, in Room 48, a 7.5-ounce container of Top Care hand soap, a 21-ounce container of Jergens lotion, and a 3.4 ounce of Old Spice Pure Sport deodorant were unsecured in the resident's room. - At 10:24 AM, in Room 46, a three-ounce container of Dry Idea deodorant and a 5.6-ounce tube of Aquafresh toothpaste were unsecured in the resident's room. - At 10:27 AM, in Room 42, an 18-ounce container of Aveeno Daily Moisturizer was unsecured in		locks will be installed to any cabinets needing locks. 3. In order to monitor correction, inspection of resident rooms and public areas will be conducted at beginning and end of each shift, Executive Director or designee will audit resident apartments a week for a period of 4 weeks. 4. HWD and Shift lead will be responsible to ensure correction. 5. Correction has been implemented on 6/30/25 with improved locked installed on 5/29/25.	

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	the resident's room. - At 10:30 AM, in Room 2, a container of Dior Savage cologne was unsecured in the resident's room. - At 10:36 AM, in Room 8, a nine-ounce container of Fresia shampoo and body wash was unsecured in the resident's room. - At 10:40 AM, in Room 12, a container of Sensodyne Pronamal, a container of Bioinfusion conditioner, a container of Dove dry shampoo, an 8.8-ounce container of Febreeze air freshener, a container of Tresemme hair mousse, a container of Argon Oil of Morocco hair mousse, and two boxes of Loreal hair color were unsecured in the resident's room. - At 10:43 AM, in Room 9, an eight-ounce container of Eucerin Eczema Relief was unsecured in the resident's room. - At 11:17 AM, in Room 21, a 32-ounce container of Rainbath, a 16-ounce container of hydrogen peroxide, and a 33-ounce container of Paul Mitchell shampoo were unsecured in the resident's room. - At 11:21 AM, in Room 15, a four-ounce container of Sensodyne toothpaste, an 8.5-ounce container of Paul Mitchel spray gel, a 3.4-ounce container of Pronamel toothpaste, and a three-ounce container of Dove Men + Care deodorant were unsecured in the resident's room. On 03/18/2025 at 9:41 AM through 11:21 AM, the Health and Wellness Director or the sister facility Executive Director confirmed the above-mentioned items could be dangerous to residents in a memory care facility and should be secured. The facility policy, "Resident Personal Care Items - ALZ-5," documented, "it is important that all areas of the community are made as safe as possible." The policy also documented "Personal care items should be labeled with the resident's name (only if there is a roommate or a community bathing area) and kept in a locked drawer or cabinet for safe use. Items may include, but not limited to: *Liquid care products such as soap, shampoo, conditioner, lotion and bulk liquid care products; *bars of soap; *toothpaste, mouthwash, denture cleaning substances such as Polident; *cologne or perfume; *deodorant. The facility policy, "Keeping Residents Safe: Sweep and Secure Hazardous Items," documented, "Chemical solutions used in dining, laundry,			

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	housekeeping, maintenance, and beauty salons should be locked at all times and secured from all residents." This was a repeat deficiency from the 05/15/2024 State Licensure regrading survey. Severity: 2 Scope: 3			
1035 SS= F	Care to Persons with Dementia - NAC 449.2768 and R043-22 Residential facility which provides care to persons with dementia: Training for employees. (NRS 449.0302, 449.094) 1. Except as otherwise provided in subsection 2, the administrator of a residential facility which 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 or she is initially employed at the facility, at least 2 hours of tier 2 training . Inspector Comments: Based on personnel file review and interview, the Administrator failed to ensure 7 of 9 sampled employees working at the facility less than a year received two hours of dementia training within 40 hours of the employee's start date (Employee #4, #5, #8, #9, #10, #12, and #13). Findings include: On 03/18/2025 at 9:16 AM, the Business Office Coordinator was provided the Personnel Check List to complete for 15 sampled employees. On 03/18/2025 at 3:30 PM with additional information emailed 03/19/2025 at 10:58 AM, the Business Office Coordinator provided the completed form with the following information: Employee #4 Employee #4 was hired by the facility as Caregiver with a start date of 02/08/2025. Employee #4's personnel record contained documentation of 1.5 hours of Tier 2 training within the employee's first 40 hours of employment. Employee #5 Employee #5 was hired by the facility as Caregiver with a	1035	1. In the statement of deficiency, it was found that 7 of the 9 sampled employees were deficient in the required 2 hours of Tier 2 Alzheimer’s training. It was shown that each of the 7 employees only had 1.5 hours of the Tier 2 training. This deficiency was corrected immediately after it was brought to our attention during our annual state audit. In order to verify that new employees complete the 2 hours of Tier 2 training, we have adjusted the number of Relias Training hours that are automatically assigned to new hires. 2. The systematic changes that we have put in place to verify that new employees will complete their required Tier 2 Training include: (1) automatically assigning Alzheimer’s and Dementia training modules in Relias, (2) the Business Office Coordinator has structured the new hire orientation so that mandatory training is completed within the first 40 hours. New hires are not permitted to start their on-the-floor training unless their Alzheimer’s and Dementia care training has been completed. 3. In order to verify that the deficient practice for Tier 2 training will not reoccur, the Business Office Coordinator has developed a training plan for new hires. During orientation, it’s discussed with new hires that their 40 hours of training will focus on prioritizing the completion of their Relias Training. The Business Office Coordinator monitors this process and verifies that these training modules are complete before each new hire is scheduled	05/01/2025

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	start date of 01/21/2025. Employee #5's personnel record contained documentation of 1.5 hours of Tier 2 training within the employee's first 40 hours of employment. Employee #8 Employee #8 was hired by the facility as Caregiver with a start date of 01/14/2025. Employee #8's personnel record contained documentation of 1.5 hours of Tier 2 training within the employee's first 40 hours of employment. Employee #10 Employee #10 was hired by the facility as Caregiver with a start date of 02/14/2025. Employee #10's personnel record contained documentation of 1.5 hours of Tier 2 training within the employee's first 40 hours of employment. Employee #12 Employee #12 was hired by the facility as Caregiver with a start date of 02/24/2025. Employee #12's personnel record contained documentation of 1.5 hours of Tier 2 training within the employee's first 40 hours of employment. Employee #13 Employee #13 was hired by the facility as Caregiver with a start date of 02/24/2025. Employee #13's personnel record contained documentation of 1.5 hours of Tier 2 training within the employee's first 40 hours of employment. On 03/18/2025 at 2:26 PM, the Health and Wellness Director provided the Attestation of Compliance form, signed and dated 03/18/2025, confirming the Administrative Assistance had conducted a thorough review of the personnel records to determine compliance and any noncompliance found. Severity: 2 Scope: 3		to train on the floor. This will verify that the Tier 2 training requirement is met. 4 .The Business Office Coordinator is responsible for overseeing the training process and ensuring that the plan of correction is implemented. To verify ongoing compliance the Executive Director or designee will audit up to 3 new associate files a week for a period of 8 weeks. 5. The corrective action was completed on 5/1/2025. Brookdale Reno submitted a request to add additional Alzheimer's and Dementia Care Training Modules during the automatic enrollment of Relias Training for new associates. This request was completed by the LMS team and new associates are now automatically assigned 8 hours of Alzheimer's and Dementia Care Training Modules when they are entered into the system.	
1037 SS= D	Care to Persons with Dementia - NAC 449.2768 and R043-22 Residential facility which provides care to persons with dementia: Training for employees. (NRS 449.0302, 449.094) 1. Except as otherwise provided in subsection 2, the administrator of a residential facility which provides care to persons with any form of dementia shall ensure that: (a) Each employee of the facility who has direct contact with and provides care to residents with any form of dementia, including, without limitation, dementia caused by Alzheimer ' s disease, successfully completes: (3) If such an employee is licensed or certified by an occupational licensing board, at least 3	1037	1. In the statement of deficiency, it was stated that 2 of the 6 sampled employees did not meet the state requirements for 3 hours of continued education for providing care to Alzheimer's and dementia residents. In order to correct this deficiency, we will provide monthly in-service trainings during mandatory all-staff meetings. These trainings will educate staff on the continued care of our residents. In doing so, this will provide	06/30/2025

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	hours of continuing education in providing care to a resident with dementia, which must be completed on or before the anniversary date of the first date the employee was initially employed at the facility. The requirements set forth in this subparagraph are in addition to those set forth in subparagraphs (1) and (2), may be used to satisfy any continuing education requirements of an occupational licensing board, and do not constitute additional hours or units of continuing education required by the occupational licensing board. (4) If such an employee is a caregiver, other than a caregiver described in subparagraph (3), at least 3 hours of tier 2 training in providing care to a resident with dementia, which must be completed on or before the anniversary date of the first date the employee was initially employed at the facility. The requirements set forth in this subparagraph are in addition to those set forth in subparagraphs (1) and (2). Inspector Comments: Based on record review and interview, the facility failed to ensure 2 of 6 sampled employees providing care to residents with dementia completed the required minimum of an additional three hours of training in providing care to a resident with dementia by the hire anniversary date (Employee #4 and #6). Findings include: On 03/18/2025 at 9:16 AM, the Business Office Coordinator was provided the Personnel Check List to complete for 15 sampled employees. On 03/18/2025 at 3:30 PM with additional information emailed 03/19/2025 at 10:58 AM, the Business Office Coordinator provided the completed form with the following information: On 09/14/23 at 1:53 PM, the Administrator provided the completed form with the following information: Employee #4 Employee #4 was hired by the facility as Caregiver with a start date of 02/08/2025. Employee #4's personnel file contained documented evidence of one additional hour of annual dementia training, less than the required three hours. Employee #6 Employee #6 was hired by the facility as Medication Technician with a start date of 12/16/2020. Employee #6's personnel file contained		each staff member with 12 additional hours of continued education for providing care to Alzheimer's and dementia residents. In addition, we will also monitor the completion of mandatory monthly Relias Training modules. 2. The management team will coordinate monthly in-service training during our mandatory all-staff meetings. These trainings will cover the necessary topics and criteria for providing care to Alzheimer's and dementia residents. This will provide each staff member with 12 annual training hours of continued care. To verify that training is being completed by each employee, we will also monitor the completion of Relias Training that is assigned to employees monthly. 3. To verify that this deficient practice will not reoccur, the Business Office Coordinator has created a weekly calendar reminder to review Relias training and coordinate with staff monitor that their assigned trainings are being completed. This will verify that training is being monitored for staff on a regular basis. These trainings will provide staff with the required 3 hours of annual caregiver training. Executive Director or designee will audit up to 3 new associate files a week for a period of 8 weeks. 4. The Business Office Coordinator is responsible for the monthly completion of Relias Training and assisting with coordinating monthly all-staff in-service training. 5. Implementation of correction started on 6/30/25	

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	documented evidence of one additional hour of annual dementia training, less than the required three hours. On 03/18/2025 at 2:26 PM, the Health and Wellness Director provided the Attestation of Compliance form, signed and dated 03/18/2025, confirming the Administrative Assistance had conducted a thorough review of the personnel records to determine compliance and any noncompliance found. Severity: 2 Scope: 1			