

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1884	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/14/2026
NAME OF PROVIDER OR SUPPLIER BROOKDALE RENO		STREET ADDRESS, CITY, STATE, ZIP CODE 3105 PLUMAS STREET, RENO, NEVADA ,89509		
(X4) ID PREFIX TAG RFG 0001- Deficiencies	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG RFG 0001- Deficiencies	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The Statement of Deficiencies was generated as a result of a state licensure survey conducted in your facility, in accordance with Nevada administrative code, chapter 449, and Nevada revised statutes chapter 449- Residential Facility for Groups (RFG), medical facilities and other related entities. The findings and conclusions of any investigation by the Division of Health Care Purchasing and Compliance shall not be construed as prohibiting any criminal civil investigation, actions or other claims for reliefs that may be available to any party under applicable federal, state or local law. Based on an inspection conducted, the items marked below identify the violation in operation of the RFG which must be corrected by the revisit/compliance date specified in writing by the health authority. Failure to comply with this notice and immediately correct the identified deficiencies may result in the suspension or termination of your provider agreement, funding, or future authorization as a provider authorized by the State			

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 Name: MOLLY RATFIELD Title: Administrator
REPRESENTATIVE'S SIGNATURE

Date: 08/13/2026

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	of Nevada pursuant to NAC 433.384, and other applicable local and state laws. Inspector Comments: This Statement of Deficiencies was generated as a result of a mandatory re-grading survey and complaint (CPT) investigation completed at your facility on 04/14/2026. The facility is licensed for 56 Residential Facility for Group beds, with assisted living services for elderly or disabled persons, and/or persons with Alzheimer's disease, Category II residents. The census at the time of the survey was 50. Six resident files were reviewed, and six employee files were reviewed. The facility received a grade of C. There were four complaints investigated. Substantiated: CPT #13372 was substantiated. (See Tag Y0590) CPT #12595 was substantiated. (See Tag Y0053 and Y0950) Unsubstantiated: CPT #12760 could not be substantiated. No regulatory deficiencies could be identified. CPT #13408 could not be substantiated. During the investigation, a deficiency related to lack of use of hair restraints during food service was identified (See Tag Y0250). The investigation into the CPTs included: Observations of resident rooms, residents while in their rooms, in the dining rooms, and in the common areas, including the residents of concern, staff-to-resident interactions, staff providing care and supervision to residents, resident lunch dining services, resident food, cleanliness of the kitchen, food preparation, and food availability and storage in the kitchen. Interviews were conducted with residents,			

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	including a resident of concern, the Clinical Specialist, a Medication Technician, the Sous Chef, the Sales Manager, and the Administrator. Reviewed the resident of concerns record to include service plan, physician orders, hospital summaries, shower records, hospice care plan and orders, physician notification reports, and admission agreement. Review of the facility policies on abuse and neglect, activities of daily living, restraints, personal alarm devices, bedside mobility devices, staffing requirements, food storage, hair restraints, food and beverage temperature control, hand washing, washing and sanitizing dishes.			
Y 0053 SS= D	NAC 449.194 4. Ensure that the records of the facility are complete and accurate. Inspector Comments: Based on record review, interview, and document review, the Administrator failed to ensure that 1 of 4 closed resident records reviewed (Resident #7) was maintained with complete and accurate documentation related to hospice care and 1 of 6 sampled residents' (Resident #4) clinical health record was complete and accurate. Findings include: Resident #7 Resident #7 was admitted to the facility on 08/22/2024, with diagnoses including dementia and protein calorie malnutrition. Resident #7 was discharged from the facility on 02/01/2026. Resident #7's record lacked evidence of a	Y 0053	1. Hospice record for resident discharged in February of 2026 was located. Order in question was obtained on day of survey. 2. On 5/6/26 pharmacy completed a cart to MAR audit of current residents to check for potential orders that could be out of compliance. Medication Technicians will be retrained to follow practice. Hospice record for discharged resident was located in the community. A resident record review of current residents on hospice was completed to verify a care plan was on file. 3. The clinical director or designee will re-train medication technicians in following practice of obtaining orders for any medications by July 3, 2026. The clinical director was re-trained regarding the interdisciplinary coordination and documentation requirements. 4. Clinical operations specialist or designee. 5. Training to be completed by July 3, 2026. 6. Hospice plan of care and copy of order are attached.	07/03/2026

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	written hospice plan of care, hospice start and stop dates, and documentation of interdisciplinary coordination of hospice services prior to discharge. On 04/15/2026 at 2:15 PM, the Administrator stated "what the facility had was all it had and could not go backward." The Administrator confirmed that the record did not contain a hospice plan of care, start and stop dates, or documentation of interdisciplinary coordination for Resident #7 prior to discharge. CPT#12595 Resident #4 Resident #4 was admitted to the facility on 05/01/2025, with diagnoses including hypothyroidism and heart failure. Resident #4's clinical record lacked documented evidence of a physician's order for Senna Plus and Promethazine. Resident #4's April 2026 MAR lacked documentation of Senna Plus and Promethazine. On 04/14/2026 at 1:20 PM, during a review of Resident #4's medications, the following medication containers were present: -A bubble pack of Senna Plus 8.6 mg-50 mg tablets. The bubble pack documented the medication was distributed by the pharmacy on 03/06/2026. -A bubble pack of Promethazine 12.5 mg tablets. The bubble pack documented the medication was distributed by the pharmacy on 03/06/2026. On 04/14/2026 at 1:20 PM, a Medication Technician (Med Tech) verbalized neither the Senna Plus and Promethazine were documented on Resident #4's MAR and confirmed both bubble packs documented a distribution date of 03/06/2026. The Med Tech confirmed neither the Senna Plus nor the Promethazine had been administered since distribution approximately one month prior. The Med Tech explained it was the responsibility of all medication technicians			

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	to audit medication carts to ensure medications were documented on the residents' MARs. The Med Tech explained if a medication in the medication cart was not on the resident's MAR, the Med Tech should reach out to the acting Health and Wellness Director (Clinical Specialist) and locate a physician's order. On 04/14/2026 at 3:47 PM, The Clinical Specialist verbalized the Clinical Specialist was unable to locate a physician's order for the Senna Plus and Promethazine distributed 03/06/2026. Severity: 2 Scope: 1			
Y 0250 SS= F	NAC 449.217 1. The equipment in a kitchen of a residential facility and the size of the kitchen must be adequate for the number of residents in the facility. The kitchen and the equipment must be clean and must allow for the sanitary preparation of food. The equipment must be in good working condition. 2. Perishable foods must be refrigerated at a temperature of 40 degrees Fahrenheit or less. Frozen foods must be kept at a temperature of 0 degrees Fahrenheit or less. 3. Sufficient storage must be available for all food and equipment used for cooking and storing food. Food that is stored must be appropriately packaged. 4. The administrator of a residential facility shall ensure that there is at least a 2-day supply of fresh food and at least a 1-week supply of canned food in the facility at all times. 5. Pesticides and other toxic substances must not be stored in any area in which food, kitchen equipment, utensils or paper products are stored. Soaps, detergents, cleaning compounds and similar substances must not be stored in any area in which food is stored.	Y 0250	1. All dishwashers have been serviced by 4/16/26 and again 5/29/26. Test strips have been obtained 4/14/26. Staff have been trained on sanitation procedures. Handwashing sinks have been stocked with supplies by 4/14/26. Hairnets stocked in kitchen 4/14/26. 2. Daily tracking of dish machine sanitation levels and temperatures has been put into place as requested by the department of health. A member of management will monitor meal service once daily to monitor for compliance with hair nets, glove use, and handwashing supplies. 3. Weekly reporting to state health inspectors for 4 weeks has been instituted following monthly reporting for the following 2 months. An assigned member of the management team will monitor meal service once daily for 2 months to observe and monitor for compliance with hair nets, glove use and handwashing supplies. 4. Dining services manager or designee responsible for sanitation monitoring with reporting to the administrator who will be responsible for health department reporting. Meal service monitoring completed by management team under the direction of the Executive Director. 5. Daily reporting went into effect 4/16/26. Reporting with be ongoing until July 8, 2026. 6. Attached logging sheets previously sent to the health department, EcoLab Service reports and staff training attached.	07/08/2026

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	Inspector Comments: Based on observation, interview and document review, the facility failed to ensure 1) quat buckets contained a sufficient amount of sanitizing agent to clean and sanitize surface areas used to prepare food, 2) staff tested for appropriate levels of sanitizing agents used in dishwashing machines and had supplies necessary to complete the testing, 3) the handwashing sink in 1 of 4 satellite kitchens was stocked with paper towels, and 4) hair restraints were worn by staff when plating food for residents. Findings include: Quat buckets On 04/14/2026 at 9:45 AM, two quat buckets were available in the main kitchen. The Sous Chef dipped a separate test strip into each bucket and compared the color on the test strips to the color chart (a manufacturer insert indicating parts per million (PPM) of sanitizer), inside the strip container. Both test strips indicated the concentration of quat sanitizer in the buckets was 100 PPM. The test strip container indicated the strips were intended for use with quat sanitizers and lacked an expiration date. On 04/14/2026 at 9:47 AM the Sous Chef verbalized the quat buckets were to be replenished every four hours and were tested each time the buckets were filled. The concentration was required to be between 200 and 250 PPM. The Sous Chef confirmed the test strips indicated the concentration of quat sanitizer in the buckets was below the required level. The Sous Chef inspected the test strip container, confirmed the container lacked an expiration date, and verbalized there were no additional testing strips available in the facility to verify the quat solution contained a sufficient amount of sanitizing agent to clean and sanitize food prep surfaces in the kitchen.			

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	On 04/14/2026 at 3:52 PM, the Clinical Specialist verbalized the facility did not have a policy related to quat sanitizer. Lack of necessary supplies and staff testing of levels of sanitizing agents in dishwashing machines. On 04/14/2026 at 9:32 AM, the Sous Chef verbalized each unit had a satellite kitchen and a dishwashing machine, all dishes were to be cleaned and sanitized on the unit. The dishwashing machine on the Country unit was currently out of order and the dishwashing machine on the Cottage unit was in need of maintenance. Staff from units where a dishwashing machine was not working would bring dishes to another unit to wash them. On 04/14/2026 at 9:56 AM, the Sous Chef started the dishwashing machine on the Garden Path unit. After the cycle was completed, the Sous Chef opened the dishwashing machine door and used a test strip to check the concentration of sanitizing solution inside the machine. The test strip turned yellow in color and did not match any of the colors on the color chart inside the strip container. The Sous Chef confirmed the color of the strip did not match any colors on the color chart. On 04/14/2026 at 10:02 AM, the Sous Chef started the dishwashing machine on the Cottage unit. After the cycle was completed, the Sous Chef used a test strip to check the concentration of sanitizing solution inside the machine. The test strip turned yellow in color. The Sous Chef confirmed the Sous Chef was using the same test strips used earlier in the day to test the quat solution in the kitchen's quat buckets and recalled the test strips had been in use for at least a month. The concentration of sanitizing solution in the dishwashing machines was tested daily by the Sous Chef. On 04/14/2026 at 10:18 AM, the Sous Chef verbalized the Sous Chef believed the sanitizing agent used in the facility's dishwashing machines was a mixture of Eco-San (a chlorinated liquid sanitizer),			

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	quat, and "another one". On 04/14/2026 at 10:21 AM, the Sous Chef unlocked a cabinet next to the dishwashing machine on the Boat House unit, containing all products used in the machine. The following were observed: a bottle of Eco-San, a bottle of all-purpose detergent, and a bottle of rinse additive. On 04/14/2026 at 10:50 AM, the Sous Chef denied the Sous Chef had documented evidence of testing of the sanitizing solution in the dishwashing machines and confirmed the facility did not have test strips intended for use with a chlorinated sanitizer. On 04/04/2026 at 1:01 PM, the Administrator verbalized the Sous Chef was supposed to be checking the temperature and the PPM of sanitizing solution in the facility's dishwashing machines and denied being aware the facility did not currently have a way to test the amount of sanitizer being used. The facility document titled "Temperature Log – Low Temp Dish Machine," revised 08/2023, documented dish machine temperatures and sanitizer levels were to be monitored and recorded every meal period. The target PPM for Eco-San and Eco-San Ultra Liquid sanitizer was 100 PPM, with a minimum of 50 PPM and a maximum of 200 PPM. The facility policy titled "Washing and Sanitizing Dishes (Machine Wash)," revised 12/2024, documented all dishes, glassware and utensils would be washed and sanitized using commercial machine washing procedures. Staff were to ensure the machine reached proper temperatures and appropriate PPMs for all chemicals were to be measured per manufacturer guidelines. Handwashing supplies On 04/14/2026 at 9:56 AM, the paper towel dispenser near the handwashing sink in the Garden Path unit satellite kitchen was not stocked with paper towels and no other paper towels or alternative methods to dry			

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	clean hands were present. The Sous Chef confirmed the satellite kitchen lacked all supplies necessary for staff to wash hands prior to and after preparing and serving meals to residents. The facility policy titled "Hand Washing," revised 09/2025, documented proper hand washing was to be used at all times. Hand washing was to be done before starting work, when hands were visibly soiled, before and after eating and after handling food. Hair restraints On 04/14/2026 at 12:07 PM, a mobile cart containing prepared food arrived in the Country unit satellite kitchen. On top of the cart were multiple hot holding areas with each item from the lunch meal in a separate tray. On 04/14/2026 at 12:11 PM, a Caregiver began plating food for residents in the Country unit. The Caregiver's hair was in multiple braids, with the top half of the hair secured and the bottom half of the hair free-flowing and extending approximately to the Caregiver's collar bone. The Caregiver was not wearing a hair restraint or hairnet. On 04/14/2026 at 12:31 PM, the Caregiver confirmed the Caregiver was plating food during lunch and was not wearing a hair restraint/hairnet. The Caregiver verbalized the Caregiver thought staff were supposed to wear hairnets to ensure hair did not end up in residents' food however, staff did not have them available to use. The Caregiver denied staff typically wore hair restraints/hairnets when plating or serving food. On 04/14/2026 at 1:01 PM, the Administrator verbalized when staff were plating food for residents, staff were expected to have hair restrained or to wear a hairnet. The Administrator explained restrained meant all hair was pulled back and secured. The facility policy titled "Hair Restraints,"			

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	revised 12/2024, documented all associates working in food preparation must wear hair restraints. All hair was to be kept covered. Acceptable hair restraints included hairnets, white paper hats, and cloth chef's hats. Hair which could not be effectively restrained by a hat was to wear a hairnet. Severity: 2 Scope: 3			
Y 0590 SS= D	NAC 449.268 Rights of residents; procedure for filing grievance, complaint or report of incident; investigation and response. 1. The administrator of a residential facility shall ensure that: (a) The residents are not abused, neglected or exploited by a member of the staff of the facility, another resident of the facility or any person who is visiting the facility; (b) A resident is not prohibited from speaking to any person who advocates for the rights of the residents of the facility; (c) The residents are treated with respect and dignity; (d) The facility is a safe and comfortable environment; (e) Residents are not prohibited from interacting socially; (f) Residents are allowed to make their own decisions whenever possible; (g) Residents are aware that they may file a complaint or grievance with the administrator and that a resident who files such a complaint receives a response in a timely manner; (h) A resident is informed as soon as practicable that he is being moved to a new room or that he is receiving a new	Y 0590	1. District Director of Clinical Operations or designee will re-train all staff on the Abuse, Neglect and Exploitation Policy, including reporting requirements by 7/3/26. 2. To monitor for on-going compliance the Clinical Director will review alert charting documentation weekly to check that any incidents have been reported in accordance with the Abuse, Neglect and Exploitation Policy for a period of 8 weeks. 3. As stated in number 2. 4. Clinical Operations Specialist or designee. 5. Training complete and reviews in place until 7/31/26.	07/31/2026

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	roommate; and (i) Residents are afforded the opportunity to initiate an advance directive or power of attorney for health care and that the employees of the facility comply with the wishes contained in such a document. 2. The administrator of a residential facility shall provide a procedure to respond immediately to grievance, incidents and complaints. The procedure must include a method for ensuring that the administrator or a person designated by the administrator is notified of the grievance, incident or complaint. The administrator or a person designated by the administrator shall personally investigate the matter. A resident who files a grievance or complaint or reports an incident pursuant to this subsection must be notified of the action taken in response to the grievance, complaint or report or be given a reason why no action needs to be taken. 3. The employees of the facility shall comply with the procedures adopted pursuant to subsection 2. Inspector Comments: Based on observation, interview, and document review, the facility failed 1) to protect a resident from physical abuse and failed to report the incident to the Aging and Disability Services Division (ADSD) as required, for 1 of 1 unsampled residents (Resident #11), and 2) to ensure a resident was provided with a bath or shower over a four-week period for 1 of 11 sampled residents (Resident #5). Findings include: Resident #11 Resident #11 was admitted to the facility on 12/11/2025. A facility report documented an alleged			

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	incident of abuse involving Resident #11 occurred on 12/24/2025; however, the incident was not reported to the appropriate agencies as required. The only report documented was submitted to the Health Care Purchasing and Compliance Division on 03/02/2026, more than two months after the incident. On 04/14/2026 at 1:24 PM, the Administrator described the facility's procedure when an allegation of abuse or neglect was suspected. The Administrator explained staff would report to their supervisor, the facility would investigate, and the Administrator would notify a corporate operations specialist. The Administrator also verbalized that an initial report would be sent to the Division of Aging Services within 24–48 hours. The facility policy titled "Abuse, Neglect & Exploitation Policy – NV-1", last revised 05/2021, documented if a determination was made there was reasonable cause to believe a resident had been abused, neglected or exploited, the Executive Director would report such information to; the local office of Aging Services Division of the Department of Human Resources, and police department or sheriff's office. The report would be made as soon as reasonably practicable but not later than 24 hours after the person knows or should have reasonable cause to believe a resident had been abused, neglected or exploited. Resident #5 Resident #5 was admitted to the facility on 10/25/2023, with diagnoses including dementia, anxiety, lower left leg amputation, major depressive disorder, and peripheral vascular disease. Resident #5's care plan dated 07/23/2025, documented showers on Fridays between 10:00 AM and 11:00 AM. Resident #5's shower cards completed from 01/01/2026 to 04/10/2026, lacked documentation the resident had received a			

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	shower or bath from 02/26/2026 to 03/26/2026. On 04/14/2026 at 3:25 PM, the Clinical Specialist verbalized the facility utilized a small piece of paper, approximately four inches by three inches in size, to document when a resident received a shower or bath or if a resident refused a shower a bath. The Clinical Specialist confirmed Resident #5's shower or bath day was Friday mornings and Resident #5's shower cards lacked documentation the resident received a shower or bath from 02/26/2026 to 03/26/2026. The Clinical Specialist verbalized a family member would sometimes provide a shower to the resident; however, those showers would not be documented on a shower card or in the resident record. The Clinical Specialist confirmed having been unsure if the resident had received a bath or shower from 02/26/2026 to 03/26/2026, due to a lack of documentation. The facility policy titled, "Activities of Daily Living (ADL) Care Documentation Policy," revised 09/2025, documented ADLs would be outlined on the resident's service plan and would be delivered to the resident as scheduled. ADL care refused by the resident would be documented in the resident record as an exception. The facility policy titled, "Abuse, Neglect and Exploitation Policy," revised 05/2021, documented the definition of neglect as a failure to provide services necessary to maintain physical and mental health of the resident. Severity: 2 Scope: 1 Complaint #13372			
Y 0850 SS= D	NAC 449.274 and R043-22 Medical care of resident after illness, injury or accident; periodic physical	Y 0850	1. Physical obtained for resident #2 on 4/20/26. 2. The Health and Wellness Director completed an audit of resident records to check for any potential missing pre-move physicals. 3. To monitor for ongoing compliance the	06/05/2026

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	examination of resident; rejection of medical care by resident; written records. 1. If a resident of a residential facility becomes ill or is injured, the resident's physician and a member of the resident's family must be notified at the onset of illness or at the time of the injury. The facility shall: (a) Make all necessary arrangement to secure the services of a licensed physician to treat the resident if the resident's physician is not available; and (b) Request emergency services when such services are necessary. 2. A resident who is suffering from an illness or injury from which the resident is expected to recover within 14 days after the onset of the illness or the time of the injury may be cared for in the facility. The decision as to the period within which the resident is expected to recover from the illness or injury and the needs of the resident must be made by the resident's physician or, if he is unavailable, by another licensed physician. 3. A written record of all accidents, injuries and illnesses of the resident which occur in the facility must be made by the caregiver who first discovers the accident, injury or illness. The record must include: (a) The date and time of the accident or injury or the date and time that the illness was discovered; (b) A description of the manner in which the accident or injury occurred or the manner in which the illness was discovered; (c) A description of the manner in which the members of the staff of the facility responded to the accident, injury or illness and the care provided to the resident. This record must accompany the resident if he or she is transferred to another facility. 4. The facility shall ensure that appropriate medical care is provided to the resident by: (a) A caregiver who is trained to provide that care; (b) An independent contractor who is trained to provide that care; or (c) A medical professional. 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition		Health and Wellness Director or designee will monitor move in required health records and schedule move-in to the community based on completion of records for a period of four weeks. 4. Health and Wellness Director or Designee 5. Health record review completed and move in process updated by 6/5/26. 6. Resident physical attached.	

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	of a resident, the facility shall obtain the results of a general physical examination of the resident by a qualified provider of health care in accordance with NRS 449.1845. The resident must be cared for pursuant to any instructions provided by the qualified provider of health care. 6. The members of the staff of the facility shall: (a) Ensure that the resident receives the personal care that he requires. (b) Monitor the ability of the resident to care for his own health conditions and shall document in writing any significant change in his ability to care for those conditions. 7. This section does not prohibit a resident from rejecting medical care. If a resident rejects medical care, an employee of the facility shall record the rejection in writing and request that the resident sign that record as a confirmation of his rejection of medical care. If the resident rejects medical care that a physician has directed the facility to provide, the facility shall inform the resident's physician of that fact within 4 hours after the care is rejected. The facility shall maintain a record of the notice provided to the physician pursuant to this subsection. 8. As used in this section, "significant change" means a change in a resident's condition that results in a category 1 resident becoming a category 2 resident or otherwise results in an increase in the level of care required by the resident. Inspector Comments: Based on resident file review, document review, and interview, the facility failed to obtain the results of a general physical examination for 1 of 6 sampled residents (Resident #2). Resident #2 was admitted to the facility on 12/29/2025, with diagnoses including Alzheimer's Disease, Hyperlipemia, and iron deficiency. Resident #2's file lacked the results of a			

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	pre-admission general physical examination of the resident by a qualified provider of health care. On 04/14/2026 at 2:51 PM, the clinical specialist confirmed Resident #2's file lacked documented evidence of any physical examination. The clinical specialist verbalized Resident #2 should have undergone a pre-admission physical examination and examination results should have been contained in the resident file. Severity: 2 Scope: 1			

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(X4) ID PREFIX TAG Y 0874 SS= C	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) NAC 449.2742 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 of any concerns noted by the person who submitted the report. <u>The report must be reviewed and initialed by the administrator.</u> Inspector Comments: Based on record review and interview, the facility failed to ensure the Administrator reviewed and initialed the written pharmacy review report within 72 hours after the administrator of the facility received the report for 1 of 6 sampled residents (Resident #1, #2, #3, #4, #5, and #6). Findings Include: The facility provided a binder containing its pharmacy review packets divided by period with the most current review packet dated 11/1/2025 through 11/13/2025. All resident consultation reports contained within the most current review packet lacked the Administrator's initials. On 04/14/2026 at 3:06 PM, the clinical specialist confirmed the pharmacy review reports for the period ending 11/13/2026, lacked Administrator's initials and acknowledged the requirement to document review by affixing Administrator's initials to the report(s). Severity: 1 Scope: 3	ID PREFIX TAG Y 0874	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 1. Updated pharmacy review completed May 6, 2026. Administrator reviewed and signed May 7th, 2026. 2. Updated pharmacy review completed May 6th, 2026. Administrator reviewed and signed May 7th, 2026. 3. Administrator or designee to review and sign recommendations made by the pharmacy within the 72 hour time frame. 4. Administrator of record or designee. 5. Pharmacy review updated May 6, 2026 with recommendations sent out to physicians May 7, 2026. 6. Pharmacy review attached.	(X5) COMPLETION DATE 05/07/202 6
Y 0878 SS= D		Y 0878	1. Over the counter medications labeling in question was corrected on the day of the	08/26/202 6

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	NAC 449.2742 5. An over-the-counter medication or a dietary supplement may be given to a resident only if the resident's physician , physician assistant or advanced practice registered nurse has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician , physician assistant or advanced practice registered nurse. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician , physician assistant or advanced practice registered nurse. The administration of over-the-counter medications and dietary supplements must be included in the record required pursuant to paragraph (b) of subsection 1 of NAC 449.2744. 6. Except as otherwise provided in this subsection, a medication prescribed by a 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		survey. 2. Pharmacy completed a MAR/cart audit 5/6/26 to monitor potential inconsistencies. Corrections made as needed. 3. Medication cart reviews to be completed weekly by medication technicians under the review of the clinical operations specialist for 12 weeks. 4. Clinical operations specialist and designee. 5. 12 week monitoring cycle complete by 8/26/26.	

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	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, interview, record review and document review, the facility failed to ensure a change order label was affixed to a medication container when the administration instructions were changed by a physician's order for 2 of 6 sampled residents (Resident #3 and #5). Findings include: Resident #3 Resident #3 was admitted to the facility on 04/15/2024, with diagnoses including Parkinson's Disease and anxiety. Physician's orders dated 06/12/2025, and Resident #3's April 2026 Medication Administration Record (MAR), documented: Clonazepam Oral Tablet 0.5 milligrams (mg) (Clonazepam)- Give 1 tablet by mouth three times a day for feeling anxious.			

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	On 04/14/2026 at 1:06 PM, during a review of Resident #3's medication, the medication technician retrieved the following medication: Clonazepam Oral Tablet 0.5 mg (clonazepam)-Give 1 tablet by mouth three times a day for 30 days. Indications: feeling anxious. The medication lacked a change label. On 04/14/2026, a Medication Technician (Med Tech) verbalized the medication was currently being administered but was unsure if there was a new order. The medication technician confirmed the MAR and instruction on the medication label for the medication on the medication cart were not the same. Resident #5 Resident #5 was admitted to the facility on 10/25/2023 with diagnoses including depression, mixed hyperlipidemia and dementia. A physician's order dated 03/01/2026, documented Loperamide Hydrochloride (HCl) oral tablet 2 mg. Give one tablet by mouth every four hours as			

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	needed for diarrhea. Resident #5's April 2026 MAR documented Loperamide HCl oral tablet 2 mg. Give one tablet by mouth every four hours as needed for diarrhea. On 04/14/2026 at 12:54 PM, during a review of Resident #5's medications, a medication container documented Loperamide HCL oral tablet 2 mg. Give one tablet by mouth four times a day as needed for diarrhea. On 04/14/2026 at 12:54 PM, a Med Tech explained the facility ensure the resident's MAR and medication labels accurately reflected physician's orders by comparing the medication label to the MAR in the electronic health record. The Med Tech explained it was important the MAR, medication labels, and physician's orders were consistent to ensure residents received the correct dose of an ordered medication. The Med Tech confirmed Resident #5's Loperamide container documented to administer every six hours while the MAR documented to administer Loperamide every four hours. The Med Tech verbalized the Loperamide container required a				

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	changer order label. Severity: 2 Scope: 1			
Y 0920 SS= D	NAC 449.2748 Medication Storage. 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 without supervision may keep his medication in his 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. 3. Medication including, without limitation, any over-the-counter-medication or dietary supplement, must be: (a) Plainly labeled as to its contents, the name of the resident for whom it is prescribed and the name of the prescribing	Y 0920	1. Over the counter medication in question was labeled on the day of the survey. 2. Pharmacy provided a MAR/cart audit 5/6/26 to monitor for any potential discrepancies or corrections needed. 3. Weekly cart audits to be completed by medication technicians under the direction of the clinical operations specialist for 12 weeks. 4. Clinical operations specialist or designee. 5. 12 week monitoring cycle to be complete by 8/26/26.	08/26/2026

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	physician; and (b) Kept in its original container until it is administered. Inspector Comments: Based on observation, clinical record review, and interview, the facility failed to ensure an over the counter (OTC) medication was labeled with the name of the prescribing physician for 1 of 6 sampled residents (Resident #6). Findings include: Resident #6 Resident #6 was admitted to the facility on 04/10/2026 with diagnoses including hyperlipidemia and hypothyroidism A physician's order, dated 03/18/2026, documented D-Mannose 500 mg capsule. Give 3 capsules by mouth every day for prophylaxis. On 04/14/2026 at 12:49 PM, during a review of Resident #6's medications, an OTC container of D-Mannos lacked a label with the prescribing physician's name. On 04/14/2026 at 12:49 PM, a Medication Technician (Med Tech) verbalized all OTC medications were to be labeled with the resident's name and the name of the physician. The Med Tech confirmed Resident #6's OTC D-Mannos container was not labeled with the prescribing physician's name. Severity: 2 Scope: 1			
Y 0950 SS= D	NAC 449.275 Residential facility that provides hospice care: Responsibilities of staff; retention of resident with special	Y 0950	1. Resident 7 was discharged 2/1/26. 2. Staff will be retrained on reporting requirements and processes by operations specialist by 7/3/2026. 3. Clinical Operations Specialist/ Designee will review weekly documentation for 12 weeks to verify ongoing compliance of appropriate notifications.	08/26/2026

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	medical needs. 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. 2. The members of the staff of the facility shall: (a) Maintain at the facility a written record of the care and services provided to a resident who receives hospice care; and (b) Report any deviation from the established plan of care to the resident's physician within 24 hours after the deviation occurs. Inspector Comments: Based on record review, document review, and interview, the facility failed to report a deviation from the established plan of care with hospice when a resident experienced falls, for 1 of 4 closed resident records reviewed (Resident #7). Findings include: Resident #7 Resident #7 was admitted to the facility on 08/22/2024, with diagnoses including dementia and protein-calorie malnutrition. Resident #7 was discharged from the facility on 02/01/2026. Resident #7's closed record lacked documented evidence of hospice communication following multiple fall events. The resident experienced falls on the following dates with no corresponding documentation of notification to the hospice		4. Clinical Operations Specialist or designee under the direction of the Executive Director. 5. Training to be completed by 7/3/26 with review period to be complete 8/26/26.	

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	agency: • 10/27/2025 • 08/09/2025 • 03/04/2025 • 10/12/2024 • 10/04/2024 • 09/24/2024 On 04/14/2026 at 11:22 AM, the Medication Technician (Med Tech) explained if a resident was on hospice, this information would be indicated in the electronic health record (EHR) and on the board located in the medication room. The Med Tech explained hospice communication occurs via phone, fax, or text, and any resident fall should be reported to the hospice agency as soon as possible. The Med Tech did not recall Resident #7 having any falls and explained if the resident had fallen, it would have been documented in the EHR as alert charting. On 04/14/2026 at 2:15 PM, the Administrator verbalized the information contained in the progress notes represented all documentation available. The Administrator confirmed if hospice notification was not documented in the progress notes, then there was no record of hospice communication following a fall existed. The facility policy titled "Hospice Guidelines," dated 02/2019, documented required for the resident record included documentation in the resident's electronic medical record progress notes related to the communication of care between the facility associated and the hospice agency. CPT#: 12595 Severity: 2 Scope: 1			
Y 1035 SS= D	NAC 449.2768 Residential facility which provides care	Y 1035	1. Upon review of employee 2, E2 began employment with Brookdale in May of 2025 in which E2 completed the required training, attached. Annual training requirements are not due to expire until 5/22/2026. 2. Training records for all team members	08/29/2026

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	to persons with Alzheimer's disease: Alzheimer's/dementia Training: 1. Except as otherwise provided in subsection 2, the administrator of a residential facility which holds an endorsement as a residential facility which provides care to persons with Alzheimer's disease or other forms of dementia pursuant to NAC 449.2754 shall ensure that: (a) Each employee of the facility who has direct contact with and provides care to residents with any form of dementia, including, without limitation, dementia caused by Alzheimer's disease, successfully completes, in addition to the training required by NAC 449.196: (1) Within the first 40 hours that such an employee works at the facility after he is initially employed at the facility, at least 2 hours of tier 2 training. (2) In addition to the training requirements set forth in subparagraph (1), within 3 months after such an employee is initially employed at the facility, at least 8 hours of tier 2 training. (3) If such an employee is licensed or certified by an occupational licensing board, at least 3 hours of continuing education in providing care to a resident with dementia, which must be completed on or before the anniversary date of the first date the employee was initially employed at the facility. The requirements set forth in this subparagraph are in addition to those set forth in subparagraphs (1) and (2), may be used to satisfy any continuing education requirements of an occupational licensing board, and do not constitute additional hours or units of continuing education required by the occupational licensing board. (4) If such an employee is a caregiver, other than a caregiver described in subparagraph (3), at least 3 hours of tier 2 training in providing care to a resident with dementia, which must be completed on or before the anniversary date of the first date the employee was initially employed at the facility. The requirements set forth in this subparagraph are in addition to those set forth in subparagraphs (1) and (2). (b) The facility maintains proof of completion of the hours of training and		reviewed to verify compliance with training rule. 3. Business office manager to monitor employee training records monthly for 3 months to verify ongoing compliance. 4. Business office manager under the direction of the Executive Director. 5. Training complete and review cycle complete by 8/26/26. 6. Training records for employee 2.	

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1884	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/14/2026
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	continuing education required pursuant to this section in the personnel file of each employee of the facility who is required to complete the training or continuing education. 2. A person employed by a facility which provides care to persons with any form of dementia, including, without limitation, dementia caused by Alzheimer's disease, is not required to complete the hours of training or continuing education required pursuant to this section if he has completed that training within the previous 12 months. Inspector Comments: Based on personnel record review and interview, the Administrator failed to ensure employees working at the facility less than one year received two hours of dementia training within 40 hours from the employee's start date for 1 of 6 sampled employees (Employee #2). Findings include: Employee #2 Employee #2 was hired by the facility as a Clinical Specialist with a start date of 02/10/2026. A training transcript was provided in the morning. Employee #2's personnel record lacked documented evidence of any dementia care training completed by the employee. On 04/14/2026 at 1:48 PM, the Business Office Manager confirmed Employee #2 lacked the required dementia care training. This was a repeat deficiency from the 11/05/2025 State Licensure resurvey. Severity: 2 Scope: 1			