DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**01/04/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A SUMMERDALE HOMES AT RIBEIRO, LLC	**1868 RIBEIRO CIRCLE, RENO, NEVADA ,89503**

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0000	Initial Comments - Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation completed at your facility on January 4, 2018 in accordance with the authority of NRS 449.0307, Powers of the Division of Public and Behavioral Health. The census at the time of the investigation was 4 residents. The sample size was 6 residents which included 2 closed records. Complaint # NV00051530 was substantiated. The allegation included: The allegation Emergency Medical Services were called two hours after the resident expired was substantiated (See Tag's Y0069 and Y0860). The allegation a resident was mistaken to have a Do Not Resuscitate order was substantiated (See Tag Y0053). 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 deficiencies were identified:	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: EUGENE GASATAYA Title: Administrator Date: 06/18/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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0053 SS= D	449.194(4) - Administrator's Responsibilities-Complete Rec - NAC 449.194 Responsibilities of administrator. The administrator of a residential facility shall: 4. Ensure that the records of the facility are complete and accurate. Inspector Comments: Based on interview and record review, the facility failed to ensure a resident's record accurately documented a Do Not Resuscitate (DNR) status for 1 of 6 sampled residents (Resident #5). Findings include: Resident #5 Resident #5 was admitted to the facility on 08/20/17, with diagnoses including dementia and hearing loss. Resident #5's records revealed a Do Not Resuscitate (DNR) sticker on the front of the record. The record lacked any documented evidence a DNR order was completed for Resident #5. On 01/04/18 at 10:55 AM, the Caregiver verbalized he, and the night shift Caregiver, believed the Resident had a DNR on file, but found out later Resident #5 did not. Severity: 2 Scope: 1	0053	Administrator has completed the review of the caregiver's training especially in the area of communication. Resident #5 was only in the process of getting into hospice care and the resident's daughter informed us that it was only the initial inquiry. Caregiver's were also reprimanded for careless assumptions. One of the caregiver was let go in the month of February after 10 years of employment at the facility.	

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0069 SS= D	449.196(1)(e) - Qualifications of Caregiver-Meet needs - NAC 449.196 Qualifications of caregivers. 1. A caregiver of a residential facility must: (e) Possess the appropriate knowledge, skills and abilities to meet the needs of the residents of the facility. Inspector Comments: Based on interview and record review, the facility failed to ensure a caregiver possessed the appropriate knowledge, skills and abilities to meet the needs of 1 of 6 sampled residents (Resident #5). Findings include: Resident #5 Resident #5 was admitted to the facility on 08/20/17, with diagnoses including dementia and hearing loss. The resident expired 12/21/17. On 01/04/18 at 12:11 PM, the Caregiver stated, "We were left with a dead body and didn't know what to do." The Caregiver verbalized he and the night shift Caregiver, had called and left two voicemail messages with the Owner/Administrator at approximately 5:30 AM and 6:30 AM on 12/21/17. The Caregiver explained they were waiting for instructions from the Owner/Administrator. On 01/04/18 at 12:41 PM, the Owner/Administrator verbalized about two hours had passed from the time of the Caregivers first voicemail message to him and the time when Emergency Medical Services were called. The Owner/Administrator explained the facility did not have a policy or procedure on situations regarding a resident death. Severity: 2 Scope: 1	0069	Administrator has completed the training for the full-time caregiver especially in remaining calm even though he was put in a very awkward, stressful position by the neglect of duty by the part-time co-worker. Part-time worker for 10 years is no longer employed and was let go last winter. Proper communication and steps for 911 situations were included in the 8 hour of annual training.	

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0860 SS= D	449.274(6)(a)(b) - Medical Care - NAC 449.274 Medical care of resident after illness, injury or accident; periodic physical examination of resident; rejection of medical care by resident; written records. 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 document in writing any significant change in his ability to care for those conditions. Inspector Comments: Based on observation, interview, and record review, the facility failed to request emergency services timely for 1 of 6 sampled residents (Resident #5). Findings include: Resident #5 Resident #5 was admitted to the facility on 08/20/17, with diagnoses including dementia and hearing loss. Resident #5's incident report, dated 12/21/17, documented the resident was found deceased at approximately 5:30 AM on 12/21/17, and the Caregiver on the night shift had left a voicemail message with the Owner/Administrator of the facility. Resident #5's record lacked documented evidence Emergency Medical Services were called. On 01/04/18 at 12:11 PM, the Caregiver stated, "We were left with a dead body and didn't know what to do." The Caregiver verbalized he and the night shift Caregiver, had called and left two voicemail messages with the Owner/Administrator at approximately 5:30 AM and 6:30 AM on 12/21/17. The Caregiver explained they were waiting for instructions from the Owner/Administrator. On 01/04/18 at 12:41 PM, the Owner/Administrator verbalized about two hours had passed from the time of the Caregivers first voicemail message to him and the time when Emergency Medical Services were called. Severity: 2 Scope: 1	0860	Administrator has severed ties with the part-time employee - ten years of caregiving experience working for Summerdale Homes @ Ribeiro LLC. His actions were indicative of a burnout taking too much work load servicing 3 facilities for groups 7 days a week with no days off.	

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0930 SS= F	449.2749(1)(a) - Resident File-Storage, Res Information - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including without limitation: (a) The full name, address, date of birth and social security number of the resident. Inspector Comments: Based on observation and interview, the facility failed to ensure 2 of 6 resident records were secured. Findings include: On 01/04/18 at 9:23 AM, two resident records were on the counter between the living area and kitchen (Resident #5 and #6). An unsupervised resident was sitting in a wheelchair in the living area. The caregiver was not present. The kitchen cabinet above the counter containing the resident files did not have a lock on it. On 01/04/18 at 9:33 AM, the Caregiver confirmed the observation and verbalized the records should have been locked up to prevent Non-Caregiver access to the records. Severity: 2 Scope: 3	0930	Administrator had completed the annual 8 hour training for the full-time caregiver. Reviews for the MAR, ADL, resident files, etc. for it's proper use and storage were covered. The full-time caregiver stated that undo stress by the action/s of his co-worker caused him to lose focus on his job priorities especially when everything seems to point to his neglect not to the part-time co-worker.	