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 _____	**01/30/2019**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
0000	Initial Comments - Inspector Comments: This Statement of Deficiencies was generated as a result of a State Licensure complaint survey conducted at your facility on 01/30/19, in accordance with Nevada Administrative Coder (NAC) Chapter 449. Residential Facility for Groups. The facility is licensed for six Residential Facility for Group beds for elderly and disabled persons with Category II residents. The census at the time of the survey was six . Complaint #NV00055564 with the allegation of staffing was substantiated (see tag Y 0085). 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 investigations, 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		
0085 SS= D	449.199(1) - Staffing-CG on duty all times - NAC 449.199 Staffing requirements; limitations on number of residents; written schedule required for each shift. 1. The administrator of a residential facility shall ensure that a sufficient number of caregivers are present at the facility to conduct activities and provide care and protective supervision for the residents. There must be at least one caregiver on the premises of the facility if one or more residents are present at the facility. Inspector Comments: Based on observation, record review and interview, the Administrator failed to ensure a enough qualified caregivers were on duty to provide proper care for 1 of 6 residents. Findings include: A Fire Department reported on 12/01/18 at 11:30 AM, the Fire Department was called to assist a resident to get back into a chair. The staff at the facility could not assist them up from the floor. The resident	0085	Facility is in compliance. For the record, the caregiver involved was permanently removed from the facility on December 2, 2018. Resident fell twice on December 1, 2018. The administrator and owner assisted the caregiver on duty once to lift the resident from the carpet floor. When the resident fell for the second time in less than 5 hours, the caregiver failed to inform the administrator and owner but called the Fire Department instead for assistance because the caregiver thought process was not to inconvenience the administrator and owner of the facility for that given day. Resident is alert and oriented and has great recollection of that day because she suffered a huge skin tear in her left wrist. The fireman pulled the resident's wrist trying to help the caregiver get the resident back to the wheelchair. The caregiver was fully aware that the resident is under hospice care but never informed them of	04/07/2019

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: EUGENE GASATAYA Title: Administrator Date: 04/07/2019

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	was not transported for medical care. On 01/30/19 at 9:30 AM, the Caregiver explained on 12/01/18, the Owner was alone and a resident fell. The Owner could not get the resident up so the Owner called the Fire Department. On 01/30/19 at 10:45 AM, Resident #1 recalled the Fire Department had to come to the home and help the Owner lift the resident up when the resident fell on 12/01/19. The resident verbalized she was not hurt but she could not get up without help. Severity: 2 Scope: 1 Complaint #NV00055564		the falls. Caregiver failed to call hospice for assistance even though the caregiver was instructed by the hospice RN to call them for any emergencies. In addition, the caregiver failed to utilize the hoyer lift in the garage that was provided by hospice care. Last but not least, the caregiver failed to write two separate incident reports detailing the falls. Resident has not had a fall since December 1, 2018. A baby room monitor was placed in the room so that the resident can be heard when calling for assistance during afternoon nap time and during sleep time. It was neglect of duty by the former caregiver that led to the resident falling because the residents repeated calls to go to the toilet were ignored. To ensure the safety and well being of the resident/s, the administrator will be responsible to follow all the safety measures already in place that paid off instantly in this particular case. The administrator will continue to do multiple unannounced visits per week and interviews with each of the residents, continue the weekly safety standup/feedback, continue to monitor, teach, and reinforce the annual Elder Abuse training from the ADSD website during the unannounced visits. Apart from the unannounced visits, the administrator will continue to interview this particular resident that had the fall via phone call to ensure that the residents toileting needs between 9 pm to 4 am are being met on a very satisfactory basis. Administrator will do multiple weekly check on the room monitor device to ensure that it is working properly and will replace it immediately should the device fail. The administrator have trained the caregivers with the NAC/NRS/Medicaid Services Manual, and made it clear to the new caregivers that any form of elder abuse	

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			will not be tolerated in any way shape or form. The new caregivers are trained to communicate all forms of challenges directly to the administrator to prevent misguided decisions and poor judgment.	