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
	413	A. BUILDING _____ B. WING _____	10/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA SUMMIT RIDGE	4880 SUMMIT RIDGE DRIVE, RENO, NEVADA ,89523

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0000	Initial Comments - Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 10/24/17. This State Licensure survey was conducted by the authority of NRS 449.0307, Powers of the Division of Public and Behavioral Health. The facility is licensed for 85 Residential Facility for Group beds for elderly and disabled persons Category I and Category II residents. The census at the time of the survey was 73. Fifteen resident files were reviewed and 16 employee files were reviewed. The facility received a grade of B. 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		

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 REPRESENTATIVE'S SIGNATURE Name: STACEY TAYLOR Title: Executive Director Date: 11/15/2017

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0106 SS= D	449.200(2)(a) - Personnel File - 1st aid & CPR - NAC 449.200 Staffing requirements; limitations on number of residents; written schedule required for each shift. 2. The personnel file for a caregiver of a residential facility must include, in addition to the information required pursuant to subsection 1, (a) A certificate stating that the caregiver is currently certified to perform first aid and cardiopulmonary resuscitation. Inspector Comments: Based on record review and interview the facility failed to ensure all caregivers in the facility received Cardiopulmonary Resuscitation (CPR) and First Aid classes. On 10/24/17 in the morning, during review of the facility employee records, the facility had no documented evidence of a CPR class being attended by the Activities Director. On 10/24/17 at 4:30 PM, the Executive Director confirmed the Activities Director does not have CPR/First Aid and it is not in the job description for the Activities Director to have CPR. On 10/24/17 at 4:30 PM, the Executive Director confirmed the facility does not have a policy concerning CPR/First Aid for the Activities Director. Severity: 2 Scope: 1	0106	Initial comments: Please note that Atria Summit Ridge has submitted this Plan of Correction in order to comply with state regulatory provisions. The preparation and submission of this Plan of Correction does not constitute an admission of fault or liability on the part of Atria Summit Ridge or an agreement by Atria Summit Ridge regarding the truth or accuracy of the facts alleged or conclusions drawn. Tag 0106 NRS 449.200(2)(a); NAC 449.200 Employee #2, Engage Life Director, will attend First Aid and CPR training on Thursday, November 30, 2017. See Attachment.	11/13/2017
0172 SS= D	449.209(2) - Health and Sanitation-Outside garbage - NAC 449.209 Health and sanitation. 2. Containers used to store garbage outside of the facility must be kept reasonably clean and must be covered in such a manner that rodents are unable to get inside the containers. At least once each week, the containers must be emptied and the contents of the containers must be removed from the premises of the facility. Inspector Comments: Based on observation and interview, the facility failed to ensure the garbage dumpster was covered. Findings include: On 10/24/17 at approximately 11:00 AM, the garbage dumpster was observed to be uncovered. At approximately 11:45 AM, the dumpster was still uncovered. On 10/24/17 at 11:51 AM, the Maintenance Director confirmed the finding and acknowledged the deficiency. Severity: 2 Scope: 1	0172	Tag 0172 NRS.449.209 Maintenance Director or Maintenance Tech will check at 9 a.m., noon. and 3 p.m. to ensure the dumpster lid is closed. The kitchen staff will ensure the dumpster is closed prior to leaving at 7 p.m. A sign has also been posted to keep the lid closed on the dumpster at all times. See Attachment.	11/03/2017

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0178 SS= F	449.209(5) - Health and Sanitation-Maintain Int/Ext - NAC 449.209 Health and sanitation. 5. The administrator of a residential facility shall ensure that the premises are clean and that the interior, exterior and landscaping of the facility are well maintained. Inspector Comments: Based on observation and interview, the facility failed to ensure the interior and exterior of the facility was clean and maintained. Findings include: On 10/24/17 during a tour of the facility: - The dumpster area had a used glove under machinery and other trash scattered in the area. - The East side of the building had lint built up on the ground and caked on a tree and shrub from the exterior vent of the laundry room. - A broken/bent drain from the second story gutter on the South side of the East Wing. - An old umbrella was observed underneath the East Wing deck. - A broken planter barrel was observed in the the courtyard. There were lose pieces of wood and metal. - Resident Room 136, observed their window blinds were broken. On 10/24/17 at 12:41, the resident in room 136 explained they had to place papers in the window to block the sun because their blinds were broken. On 10/24/17, the Maintenance Director confirmed the findings and acknowledged the deficiencies. Severity: 2 Scope: 3	0178	Tag 0178 NRS 449.209 (5); NAC 449.209 The dumpster area was cleaned with power washing and all garbage and unnecessary items were removed. (See Pictures) The lint buildup on the eastside of the community was removed and the dryer vents were cleaned. (See Pictures) We received a proposal to repair the broken drain/rain gutter. (See Attachment) The umbrella was removed from the area underneath the community. (See Pictures) The broken planter was removed in the gardening area. (See Picture) The blinds were replaced in room 136. (See Picture)	11/15/2017
0876 SS= D	449.2742(4) - Medication Administration NRS 449.0302 - NAC 449.2742 Administration of medication: Responsibilities of administrator, caregivers and employees of facility. 4. Except as otherwise provided in this subsection, a caregiver shall assist in the administration of medication to a resident if the resident needs the caregiver's assistance. A caregiver may assist the ultimate user of controlled substances or dangerous drugs only if the conditions prescribed in subsection 6 of NRS 449.0302 are met. Inspector Comments: Based on record review and interview, the facility failed to follow Ultimate User Agreement designations for 3 of 17 residents. (Resident #1, #2 and #4). Findings include: On	0876	Tag 0876 NRS 449.2742 (4); NRS 449.0302-NAC 449.2742 RSD removed the Skintegrity and powder from the room of Resident #1. RSD removed the saline spray and lubricating eye drops from the room of Resident #2. RSD obtained a doctor's order for the medicated shampoo found in the room of Resident #4. (See Attached)	11/10/2017

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	10/24/17 in the morning and afternoon, during a tour of the facility and a review of resident files revealed the following: Resident #1 Resident #1 was admitted on 11/20/15. During a tour of the facility, observed Arglaes Powder and Skintegrity in the resident's bathroom cabinet. A review of the resident's Ultimate User Agreement signed on 11/20/15, reflected the facility was responsible for possessing and administering the medications. The resident's file also lacked documented evidence of their physician authorizing the resident to self-administer the above named medications. Resident #2 Resident #2 was admitted on 03/20/16. During a tour of the facility, observed Lubricating Eye Drops and Saline Nasal Spray in the resident's bathroom cabinet. A review of the resident's Ultimate User Agreement signed on 03/17/16, reflected the facility was responsible for possessing and administering the medications. The resident's file also lacked documented evidence of their physician authorizing the resident to self-administer the above named medications. Resident #4 Resident #4 was admitted on 7/16/16. During medication review a bottle of Ketoconazole 2% shampoo was missing. The Medication Technician verbalized the resident keeps it in his room. A review of the resident's Ultimate User Agreement signed by his POA on 07/08/16, reflected the facility was responsible for possessing and administering the medications. The resident's file also lacked documented evidence of their physician authorizing the resident to self-administer the above named medications.			
0920 SS= F	449.2748(1-2) - Medication Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. 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.	0920	Tag 0920 NRS 449.2748 (1-2); NAC 449.2748 The community will continue to implement the following for medication storage: Letters will be sent twice a year to Responsible Party about proper medication storage (See Attachment), Manager on Duty will perform daily room checks so that all rooms are checked two times per month for proper medication storage (See Attachment), ED and RSD will address proper medication storage at monthly	11/15/2017

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	Medication 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. Inspector Comments: Based on observation and interview, the facility failed to ensure medications were secured at all times in a medication cart and in 6 of 33 resident rooms inspected. Findings include: On 10/24/17 in the morning, during a tour of the facility the following was observed: In Room 103, the resident was authorized to administer their medications. Two white Tylenol pills and one round blue/green pill was observed on a dish next to the sink below the microwave. The resident's door was unlocked and they were not in their room at the time of inspection. In Room 109, the resident was authorized to administer their medications. In the resident's bathroom, observed Neosporin, Refresh Tears, Campho Phenique and New Skin. At 9:55 AM, the resident explained they do not lock their door when they leave their room. In Room 112, the resident was authorized to administer their medications. In the resident's bathroom, observed Mentholatum, Debrox Earwax Removal, Emergen-C 1,000 milligrams (mg) and Polysporin. The resident's door and their locking medicine cabinet were unlocked. The resident was not in their room at the time of inspection. In Room 113, the resident was authorized to administer their medications. In the resident's bathroom, observed Itching Eye Drops and several bottles of various Vitamins. At 10:05 AM, the resident explained they never lock their room. In Room 117, the resident was authorized to administer their medications. In the resident's room, observed a bottle of Melatonin on a table and a bottle of Aspirin in the bathroom. At 10:16 AM, the resident explained they do not lock their medicine		Resident Council and Quarterly Family Meetings and the topic will be discussed randomly throughout the year in the monthly newsletter.	

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	cabinet nor their door when they are in or out of the room. In Room 120, the resident was authorized to administer their medications. In the resident's bathroom, observed two bottles of Robitussin, a bottle of Opcon-A eye drops and a bottle of Tylenol. The resident's door and medicine cabinet were unlocked and they were not in their room at the time of inspection. On 10/24/17 in the morning and afternoon, the Maintenance Director confirmed the findings and acknowledged the deficiencies. This was a repeat deficiency from the 01/10/17 and the 12/01/16 annual State Licensure surveys. Severity: 2 Scope: 3			