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 _____	**04/09/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSET RENO MEMORY CARE	**6205 SHARLANDS AVE, RENO, NEVADA ,89523**

(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 investigation conducted at your facility on 04/09/24 in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility was licensed for one hundred three (103) Residential Facility for Groups beds which provides assisted living services for elderly or disabled persons and/or persons with chronic illness and/or persons with mental illness and/or persons with Alzheimer's disease, fifty-five (55) Category II Alzheimer's residents and forty-eight (48) Category II non-Alzheimer's residents. The census at the time of the survey was 26. One resident record was reviewed, and one employee personnel file was reviewed. One complaint was investigated. Complaint #NV00070779 with the allegation the facility failed to prevent a resident in Memory Care from eloping from the facility was substantiated (See Tag Y515). The investigation into the allegation included: Observations of resident rooms and bathrooms, staff and resident interactions, door alarm system, and staff response to resident call lights. Interviews with the Executive Director, a Maintenance Technician, and the Wellness Director. Review of the facility's Residence and Care Agreement, Elopement/Missing Resident policy, and Emergency Management policy. 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: JESUS J BARRIO Title: Executive Director Date: 04/30/2024

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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0515 SS= D	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 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, document review and interview, the facility failed to provide protective supervision to prevent a resident from eloping (Resident #1). Findings include: Resident #1 Resident #1 was admitted to the facility on 11/17/23, with diagnoses including dementia and hypertension. On 04/09/24, the Executive Director verbalized Resident #1 frequently verbalized wanting to go home, and had pulled the fire alarm several times in the past. On the evening of 03/24/24 Resident #1 was able to pull the fire alarm, and successfully eloped from the facility. An incident report, dated 03/24/24, documented after one hour of searching, the police found the resident at a nearby gas station. When emergency services was not able to reach the facility to return the Resident #1, Resident #1 was taken to a nearby hospital. Complaint #NV00070779 Severity: 2 Scope: 1	0515	1. 1. Resident personal Service Plan and ElopementRisk Assessment Updated Exit door painted same as wallcolor, new extra alarm added for door. 2. 2. All Resident elopement risk assessment reviewedalong with service plans. 3. 3. Resident care director/ memory care director ordesignee to review service plan and elopement risk assessment as needed and onan annual basis. Keep a list of residents reviewed. 4. 4. Residentcare director/ memory care director or designee to review. 5. 5. May 1, 2024	04/30/2024