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 _____	**09/14/2021**

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 State Licensure complaint survey conducted at your facility on 09/14/21, 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 #NV00064732 with the following allegations was substantiated: Allegation #1: No emergency contact numbers could be found by emergency personnel responding to a call at the facility could not be substantiated due to a lack of evidence. Allegation #2: Caregivers were unavailable and could not be located by emergency personnel responding to a call at the facility (See Tag Y0085 and Y0593). 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	Staffing - Cg on Duty All Times - NAC 449.199 Staffing requirements 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 document review and interview, the Administrator failed to ensure a Caregiver, who was hard of hearing, was able to provide care and supervision for the residents in the facility	0085	0085 Facility is in compliance. Administrator has given instructions to the caregiver that the hearing aids must be charged only at meals times so she can see all the residents without the need of the hearing aid. Although hearing aids are expensive, the caregiver will buy another set once monies are saved. A motion detector was placed under the resident #1 bed so that assistance can be given immediately once the resident starts to leave the bed for any reason. The caregiver was instructed to stay in the living room at night with her hearing aid on so she can hear resident's	09/15/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: EUGENE GASATAYA Title: Administrator Date: 01/27/2022

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	during the night shift. Findings include: On 08/27/21, a resident had fallen in their room and was yelling out for a Caregiver to help. A resident in a nearby room rushed to the kitchen to place a call to 911 emergency dispatch. An ambulance arrived at the facility and attempted to locate a Caregiver. A Caregiver could not be located by emergency personnel at the facility. After some time, a Caregiver emerged from the back of the facility, seeming to be dazed and confused. Resident #1 Resident #1 was admitted to the facility on 08/25/21, with diagnoses including cervical disc syndrom, lumbar disc disease, skin cancer and depression. Resident #1's public guardianship paperwork dated 07/30/21, documented the resident required protective supervision. Resident #1's Activities of Daily Living (ADL) log dated 08/25/21, documented the resident needed assistance with toileting, dressing, feeding and ambulation. On 09/14/21 at 9:30 AM, the Caregiver explained Resident #1 had fallen in their room and Resident #2 had heard Resident #1's cries for help. Resident #2 went in the kitchen to get a phone to call 911 emergency dispatch. An ambulance showed up at the facility and took Resident #1 to the hospital. The Caregiver on shift was hard of hearing and did not hear the resident crying for help after the fall. The Caregiver on shift was sleeping in the back of the house and was awakened to find text messages and missed phone calls. The Caregiver verbalized the Caregiver on shift that night had no idea Resident #1 had fallen and needed assistance and had no idea an ambulance had come to the facility to take Resident #1 to the hospital. In addition, the Caregiver explained there were no call bells in Resident #1's room and staff listen for the resident to yell if they need any assistance. On 09/14/21 at 9:46 AM, the Administrator explained they had received a call from the Fire Department informing the Administrator a resident had fallen at the facility and a Caregiver could		call for help when the need arises.	

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	not be located. The Administrator verbalized the Caregiver on shift had taken their hearing aides out for the night to charge. Once the hearing aids were charging, the Caregiver then put earbuds in their ears to listen to music. The Caregiver was not aware a resident had fallen. The Caregiver observed the kitchen lights come on; however did not get out of bed to investigate why the lights were on. A resident had called 911 emergency dispatch to report the need for assistance for a fellow resident that had fallen in the home. An ambulance arrived at the facility and took the resident who had fallen to the hospital and could not locate a Caregiver. The Administrator confirmed the Caregiver did not provide proper supervision and follow up for a resident who fell and needed assistance, did not get out of bed to investigate why lights were being turned on in the kitchen and the Caregiver did not have their hearing aides in to be able to hear a resident yelling for help. The Administrator explained two residents sundown and will often get up in the middle of the night. When the residents get up at night, they will turn lights on and off and rummage through the kitchen. As a result, the Caregiver paid no attention to the activity in the home, resulting in a resident yelling for help from falling and the Caregiver neglecting to respond. The Administrator verbalized it was inappropriate for the Caregiver to remove their hearing aides, not investigate nor had no idea an ambulance had taken a resident out of the facility. Severity: 2 Scope: 1 #NV00064732			
0470 SS= F	Telephones & Telephone Numbers - NAC 449.232 Telephones; emergency telephone numbers for each resident; listing of facility ' s telephone number. (NRS 449.0302) 1. Each residential facility shall have a telephone that the residents may use to make local calls. 2. A list of telephone numbers to be called in case of an emergency for each resident must be	0470	0470 Facility is in compliance. Emergency phone list is always posted in the administrator's room. Administrator will add additional emergency phone list near the telephone but keep it away from previous visitors who have taken the liberty to contact other family members on a non-emergency basis	09/15/2021

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	located near the telephone. The list must include the telephone number of the resident ' s physician and the telephone number of a friend of the resident or one of the members of the resident ' s family. 3. The telephone number of the facility must be listed in the telephone directory under the name of the facility. Inspector Comments: Based on observation and interview, the facility failed create and post a list of telephone numbers to be called in case of an emergency, which resulted in emergency personnel called to assist a resident who had fallen, not being able to contact anyone associated with the facility. Findings include: On 08/27/21, a resident had fallen in their room and was yelling out for a Caregiver to help. A resident in a nearby room rushed to the kitchen to place a call to 911 emergency dispatch. An ambulance arrived at the facility and attempted to locate a caregiver. A Caregiver could not be located by emergency personnel at the facility. As a result, the emergency personnel searched the facility for an emergency phone list to be able to contact and could not locate an emergency phone list. One emergency personnel agent stayed at the facility while the other emergency personnel took the resident to the hospital as a result of a fall. On 09/14/21 at 8:30 AM, during a tour of the facility, an emergency phone list could not be located. On 09/14/21 at 8:38 AM, the Caregiver attempted to find an emergency phone list and could not locate. The Caregiver confirmed no emergency contact phone list could be located and was not posted. The Caregiver verbalized if there was a situation at the facility, the Caregivers know each others numbers and how to contact one another. The Caregiver verbalized the residents did not know any of the Caregivers phone numbers, nor any other number associated with the facility to contact in case of an emergency. Severity: 2 Scope: 3 #NV00064732		without getting thru proper channels.	

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0593 SS= D	Rights of Residents; Procedure for Filing - NAC 449.268 Rights of residents; procedure for filing grievance, complaint or report of incident; investigation and response. (NRS 449.0302) 1. The administrator of a residential facility shall ensure that: (d) The facility is a safe and comfortable environment; Inspector Comments: Based on interview and document review, the facility failed to ensure a Caregiver on the night shift, was able to hear a resident yelling for help after they fell in their room, resulting in the resident being transferred to the hospital for assessments for 1 of 6 residents (Resident #1). Findings include: Resident #1 Resident #1 was admitted to the facility on 08/25/21, with diagnoses including cervical disc syndrome, lumbar disc disease, skin cancer and depression. On 08/27/21, Resident #1 had fallen in their room and was yelling for help. The Caregiver on duty had taken their hearing aides out to charge and put earbuds in their ears to listen to music. The Caregiver could not hear the resident yelling for help. Another resident in the facility went to investigate and upon discovering Resident #1 on the floor, the resident went to the kitchen to retrieve the telephone to call 911 emergency dispatch. Emergency personnel arrived at the facility and could not locate a Caregiver. Resident #1 was transferred to the hospital, unknowingly to the Caregiver on duty. On 09/14/21 at 9:30 AM, the Caregiver verbalized Resident #1 fell trying to get out of bed on their own. The resident began yelling for help. Another resident in the facility investigated the yelling and discovered Resident #1 on the ground yelling for help. The resident called 911 emergency dispatch for help. Emergency personnel arrived and took Resident #1 to the hospital. The Caregiver explained the Caregiver on duty on 08/27/21, was hard of hearing and could not hear the resident screaming. The Caregiver confirmed	0593	0593 Rights of residents, procedure for filing grievance, complaint, or report of incident, investigation, and response. NRS 449.268 Facility is in compliance. Caregiver will only charge hearing aids if needed when serving meals so monitoring residents will be possible without hearing for a brief moment. Caregiver was instructed by the Administrator that only one earbud is to be used for listening to music especially at night. After further investigation, the administrator has concluded that one of the resident called 911 without asking assistance from the caregiver on duty. The resident is able to ambulate throughout the facility unassisted using the wheelchair but did not go to the caregiver's room to ask for assistance for the need of another resident. With the administrator's assistance in caregiving duties along with the new caregiver in training, two caregivers will always be on duty at nighttime. The three caregivers including the administrator will ensure that the facility is a safe and comfortable environment for the residents.	09/15/2021

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	Resident #1 had fallen, was yelling for help and the Caregiver on duty failed to hear the resident screaming and did not investigate the situation. On 09/14/21 at 9:46 AM, the Administrator verbalized Resident #1 had fallen out of bed and was screaming for help. The Caregiver on duty had taken their hearing aides out to charge them and could not hear the resident screaming for help. Another resident had called 911 emergency dispatch to help Resident #1. The Administrator confirmed the Caregiver could not hear a resident yelling for help, did not investigate the situation and had no knowledge of the situation nor the resident being transferred to the hospital. The Administrator verbalized it was inappropriate for the Caregiver to not have their hearing aides in during their shift which resulted in a resident falling out of bed and not receiving proper care after the fall from the Caregiver. Severity: 2 Scope: 1 NV#00064732			