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 _____	**02/15/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA SUMMIT RIDGE	**4880 SUMMIT RIDGE DRIVE, 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: Regalado, Heather This Statement of Deficiencies was generated as a result of a State Licensure annual survey and a complaint (CPT) investigation conducted in your facility on 01/17/23 and completed on 02/15/23, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 85 Residential Facility for Group beds for elderly and disabled persons, and/or chronic illness, and/or mental illness and/or providing assisted living services, 63 Category I residents and 22 Category II residents. The census at the time of the survey was 73. Fifteen resident files and five closed records were reviewed. Fifteen employee files were reviewed. The facility received a grade of D. There was one CPT investigated. CPT #NV00067960 with the allegation the facility failed to perform cardiopulmonary resuscitation (CPR) after a resident choked could not be substantiated due to a lack of evidence. The investigation into the allegation included the following: Interviews were conducted with the Executive Director and Maintenance Director. Record review included Incident Reports and Physician Orders for Life-Sustaining Treatment forms. Document review included staff schedule for 01/21/23 and personnel review for current CPR training. Facility policy review included Emergency Response and Healthcare Decision Making. A deficiency unrelated to the allegations was identified (see tag Y0450). NAC 449.27706 Resurvey: Application and fee; failure to comply. 2. If the Bureau issues a placard to a residential facility that includes a grade of "C" or "D," the administrator must submit an application to the Bureau for a resurvey of the facility not later than 30 days after the facility receives the placard. The fee for an application for a resurvey is $600 and must accompany the application. 3. The Bureau	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: NATASHA STIEG Title: Executive Director Date: 03/31/2023

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	may revoke the license of a residential facility that is required to submit an application for a resurvey pursuant to subsection 2 if the facility fails to submit the application in accordance with the provisions of that subsection. 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:			

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0053 SS= D	Administrator's Responsibilities-Complete Rec - NAC 449.194 Responsibilities of administrator. (NRS 449.0302) The administrator of a residential facility shall: 4. Ensure that the records of the facility are complete and accurate. Inspector Comments: Based on record review, document review and interview, the Administrator failed to ensure tuberculosis (TB) testing records were complete, including the time given and/or time results read, for 2 of 15 sampled residents (Resident #1 and #4). Findings include: Resident #1 Resident #1 was admitted to the facility on 10/28/21 with diagnoses including alcohol use disorder, cognitive dysfunction, alcohol related, hyperlipidemia and vitamin B-12 deficiency. Resident #1's clinical record documented an annual TB test given on 06/20/22 and read negative on 06/22/22. Resident #1's TB testing lacked evidence of the time given and the time read. On 01/17/23 at 1:36 PM, the Resident Services Director confirmed the TB record for Resident #1 lacked the time given and the time read and the standard of practice of reading the TB test between 48 and 72 hours could not be verified without times. Resident #4 Resident #4 was admitted to the facility on 11/05/22 with diagnoses including recurrent falls, pelvic fracture, hypothyroidism and hypertension. Resident #4's clinical record documented a two step admission TB test with the first step given on 09/20/22 and read negative on 09/22/22. The second step TB test was given on 09/27/22 with a negative result, but lacked documentation of a read date and time. On 01/17/23 at 1:42 PM, the Resident Services Director confirmed the TB record for Resident #4 lacked a read date and time of the second TB and the standard of practice of reading the TB test between 48 and 72 hours could not be verified without the date and time. Severity: 2 Scope: 1	0053	The community is working with “Your Main Lab” to perform and document all resident and employee annual TB testing. The Executive Director and Resident Services Director will audit the results received to ensure the read date and time have been noted properly. The Executive Director also met with the Lab administrator to discuss what information is required when reporting TB results.	03/28/2023

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0250 SS= D	Kitchens- Equipment Works; Clean And Sanitary - NAC 449.217 Kitchens; storage of food; adequate supplies of food; permits; inspections. (NRS 449.0302) 1. The equipment in a kitchen of a residential facility and the size of the kitchen must be adequate for the number of residents in the facility. The kitchen and the equipment must be clean and must allow for the sanitary preparation of food. The equipment must be in good working condition. Inspector Comments: Based on observation, interview, and document review, the facility failed to ensure hair restraints were worn by staff in the facility's kitchen. Findings include: On 01/17/23 at 9:10 AM, during a tour of the facility's kitchen, two staff members were in the kitchen and were not wearing any form of hair restraint. The two staff members were working with food. On 01/17/23 at 9:12 AM, a cook communicated staff were not required to wear hair nets and ponytails were used to restrain hair. On 01/17/23 at 1:24 PM, the Director of Culinary communicated hair nets were to be worn when staff were behind the tray line. On 01/17/23 at 1:26 PM, the Executive Director confirmed hats or hairnets had to worn in all areas of the kitchen. The facility policy titled "Uniform Policy," dated 02/28/17, documented employees were expected to dress in a manner appropriate for the nature of the work performed. Chefs and cooks wore chef hats and utility staff wore hats or hair nets. Severity 2, Scope 2	0250	The Executive Director and Director of Culinary Services met with the culinary staff to review proper way to restrain hair when behind the tray line. Atria’s Uniform Policy was also reviewed during the in service	03/27/2023
0252 SS= F	Storage of Food - Adequate Storage; Packaging - NAC 449.217 Kitchens; storage of food; adequate supplies of food; permits; inspections. (NRS 449.0302) 3. Sufficient storage must be available for all food and equipment used for cooking and storing food. Food that is stored must be appropriately packaged. Inspector Comments: Based on observation	0252	The Executive Director and Director of Culinary Services hosted an in service with the culinary staff to discuss proper food storage and labeling. Atria’s policy was also reviewed during the in service.	03/27/2023

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	and interview, the facility failed to ensure food was stored in sealed containers and food storage area was kept free of debris. Findings include: On 01/17/23 between 9:31 AM and 9:48 AM, during a tour of the facility kitchen's walk-in refrigerator and freezer, with a facility Cook, the following food items were stored in open and unsealed containers and/or were not labeled or dated with a date opened or an expiration date: Walk-in refrigerator: -shredded parmesan cheese, unlabeled and open, -shredded Monterey Jack cheese with a best buy date of 03/30/23, was open and did not include the date opened, -Large bag of shredded yellow cheese was open, unsealed, and unlabeled, -One pie, was not labeled and was not dated, -One large box of Bok choy (12+ bunches) was wilted and darkened, -A box of Pillsbury croissants with date of 04/08/22, was open, unsealed, and unlabeled by the facility. -A container of hollandaise sauce was labeled with an open date 01/11/23. -Eight jars of homemade garlic butter were not labeled or dated. Freezer: -One bag labeled chicken pho broth and one bag of fettucine noodles were found on the floor. -box of burger patties, open and not sealed. On 01/17/23 at 9:46 AM, the Cook confirmed the leftovers were not labeled and dated. Leftovers were to be labeled, dated, and discarded after three days. The cook confirmed when food items were opened, the food should be labeled and should include a date opened. On 01/17/23 at 9:48 AM, the confirmed bok choy was wilted, darkened and was not acceptable to serve. The Cook confirmed the bok choy should have been removed from the walk-in. The cook confirmed the open box of burger patties in the freezer should have been sealed and should not have been left open to air. On 01/17/23 at 9:50 AM, during a tour of the facility's kitchen dry good storage, with a facility Cook, the following food items were stored in open and unsealed containers: -One large bag of shredded coconut was open			

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	and unsealed, -One 24-ounce (oz) bag of country style gravy mix was open and unsealed, -One 32 oz bag of sliced almonds was open and unsealed, -One large bag of long grain rice was open and unsealed, - One large bag of brown rice was open and unsealed, - One 10-pound (lb.) bag of quinoa was open and unsealed, -One 5 lb. bag of pancake mix was open and unsealed, -One 48 oz bag of tortilla strips was open and unsealed, and -One large bag of croutons was open and unsealed. On 01/17/23 at 9:55 AM, the cook confirmed all foods should be sealed with a knot or rubber tie. The Cook communicated the Cook thought it was acceptable to fold the tops of the bags over and had not been trained to seal the bags using another method. The facility policy titled "Food Storage: Dry Goods, Refrigerator and Freezer Units," dated 03/30/11, documented all opened food containers or food removed from its original container was properly covered/sealed, dated, and labeled as to the contents. All left over food stored in refrigeration units was discarded 72 hours after the initial preparation and use of the food item. The food storage areas and entire kitchen were kept free of spoiled, outdated, or expired food. The facility policy titled "Food Storage: Covering, Dating and Labeling foods," dated 01/22/18, documented food must tightly covered using lids, plastic wrap, foil, or another approved method. Labels included the name of the food item, the opened/created date, the use by date, and nay other state required information. Severity: 2 Scope: 3			
0450 SS= F	First Aid & CPR - NAC 449.231 First aid and cardiopulmonary resuscitation. (NRS 449.0302) 1. Within 30 days after an administrator or caregiver of a residential facility is employed at the facility, the administrator or caregiver must be trained in first aid and cardiopulmonary resuscitation. The advanced certificate in first aid and adult cardiopulmonary resuscitation issued by the American Red	0450	The Executive Director and Community Business Director have audited all employee files to ensure accuracy and completion of the First Aid/CPR course in a timely manner. The community has partnered with a company that can come to the community to teach the course in groups. An internal tracker has been created to keep track of expiration dates monthly.	03/28/2023

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	Cross or an equivalent certification will be accepted as proof of that training. Inspector Comments: Based on record review and interview, the facility failed to ensure employees obtained timely first aid and cardiopulmonary resuscitation (CPR) training for 6 of 10 sampled employees working at the facility greater than 30 days (Employee #3, #5, #6, #10, #12, and #13). Findings include: Employee #3 Employee #3 was hired as Engage Life Director with a start date of 08/03/20. Employee #3's employee file contained a first aid and CPR training certificate dated 08/06/20. Employee #3 was scheduled to take a first aid and CPR training 01/17/23, 163 days beyond the two-year expiration date. Employee #5 Employee #5 was hired as Resident Services Assistant with a start date of 06/29/11. Employee #5's employee file contained a first aid and CPR training certificate dated 04/10/20 and a first aid and CPR training certificate dated 05/17/22, 36 days beyond the two-year expiration date. Employee #6 Employee #6 was hired as Resident Services Assistant with a start date of 06/29/11. Employee #6's employee file contained a first aid and CPR training certificate dated 12/04/18. Employee #6 was 773 days beyond the two-year expiration date. Employee #10 Employee #10 was hired as Cook with a start date of 09/22/22. Employee #10's employee file lacked a first aid and CPR training certificate. Employee #7 was scheduled to take first aid and CPR training 01/31/23, 87 days beyond the 30-days allowed. Employee #12 Employee #12 was hired as Resident Medication Assistant with a start date of 06/21/22. Employee #12's employee file contained a first aid and CPR training certificate dated 09/07/22, 48 days beyond the 30-days allowed. Employee #13 Employee #13 was hired as Resident Services Assistant with a start date of 12/22/21. Employee #13's employee file contained a first aid and CPR training			

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	certificate dated 05/25/22, 124 days beyond the 30-days allowed. On 01/17/23 at 12:32 PM, the Executive Director provided the Attestation of Compliance form, signed and dated 01/17/23, confirming the Corporate Executive Director had conducted a thorough review of the personnel records to determine compliance and any noncompliance found. The Corporate Executive Director verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. Employee #20 was hired as Resident Services Assistant with a start date of 04/17/20. Employee #20's employee file contained a first aid and CPR training certificate dated 04/25/19 and 01/31/23. The CPR training was renewed 646 days beyond the two-year expiration date. On 02/15/23 at 11:24 AM, the Executive Director confirmed Employee #20 had completed the CPR training late. Severity: 2 Scope: 3			
0859 SS= E	Medical Care of Resident After Illness - 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. (NRS 449.0302) 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by his or her physician. The resident must be cared for pursuant to any instructions provided by the resident ' s physician. Inspector Comments: Based on interview and clinical record review, the facility failed to ensure a general physical examination was completed upon admission and/or annually for 4 of 15 sampled residents (Resident #1, #2, #7 and #9). Findings include: Resident #1 Resident #1 was admitted to the facility on 10/28/21, with diagnoses including alcohol use disorder, cognitive dysfunction, alcohol related, hyperlipidemia and vitamin B-12 deficiency.	0859	Atria Summit Ridge uses an internal tracker to advise when a physician's report is coming due on an annual basis. Even though the reports were sent to the doctor offices for renewal in a timely manner and followed-up diligently, the reports were not received back from the doctors timely. Going forward, the Community will call doctor offices weekly in the event the report is not returned timely.	03/28/2023

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	Resident #1's clinical record documented an admission general physical examination dated 10/26/21. Resident #1's clinical record lacked documented evidence an annual general physical exam had been completed in 2022. Resident #2 Resident #2 was admitted to the facility on 11/30/21, with diagnoses including hypertension and hypothyroidism. Resident #2's clinical record lacked documented evidence of an admission general physical examination and an annual general physical exam for 2022. On 01/17/23 at 1:40 PM, the Resident Services Director confirmed Resident #1 lacked documented evidence of an admission general physical exam and Resident #2 lacked documented evidence of an admission and annual general physical examination and verbalized general physical examinations were to be completed upon admission to the facility and annually thereafter. Resident #7 Resident #7 was admitted to the facility on 10/22/20, with diagnosis including pulmonary embolism. Resident #7's file contained a physical examination dated 10/22/20 and 05/02/22. Resident #7's record lacked documented evidence of an annual physical examination for 2021. On 01/17/22 at 1:52 PM, the Resident Services Director confirmed the facility lacked an annual physical examination for Resident #7 for 2021. Resident #9 Resident #9 was admitted to the facility on 06/09/17, with diagnoses including acute kidney failure, muscle weakness and diabetes mellitus. Resident #9's last physical was dated 09/16/20. On 01/17/23 at 1:57 PM, the Resident Services Director confirmed the facility lacked documented evidence the Resident had an annual physical in 2021 and 2022. Severity: 2 Scope: 2			

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0870 SS= D	Medication Administration-Accuracy & Report - NAC 449.2742 Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall: (a) Ensure that a physician, pharmacist or registered nurse who does not have a financial interest in the facility: (1) Reviews for accuracy and appropriateness, at least once every 6 months the regimen of drugs taken by each resident of the facility, including, without limitation, any over-the-counter medications and dietary supplements taken by a resident; and (2) Provides a written report of that review to the administrator of the facility. (b) Include a copy of each report submitted to the administrator pursuant to paragraph (a) in the file maintained pursuant to NAC 449.2749 for the resident who is the subject of the report. (c) Make and maintain a report of any actions that are taken by the caregivers employed by the facility in response to a report submitted pursuant to paragraph (a). Inspector Comments: Based on clinical record review, document review and interview, the Administrator failed to ensure a six-month pharmacy review had been completed for 1 of 15 sampled residents (Resident #1). Findings include: Resident #1 Resident #1 was admitted to the facility on 10/28/21, with diagnoses including alcohol use disorder, cognitive dysfunction, alcohol related, hyperlipidemia and vitamin B-12 deficiency. Resident #1's clinical record documented a six month pharmacy profile review dated 05/22/22, one month late. The review was due no later than 04/28/22. On 01/17/23 at 1:36 PM, the Resident Services Director confirmed the initial six month pharmacy profile review was one month late and verbalized the reviews needed to be completed every six months. Severity: 2 Scope: 1	0870	Atria Summit Ridge conducts quarterly reviews of pharmacy records. Moving forward resident paperwork will be marked with the Quarter in which the inspection must be completed.	03/28/2023

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0874 SS= C	Medication Administration-Report Received - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 2. Within 72 hours after the administrator of the facility receives a report submitted pursuant to paragraph (a) of subsection 1, a member of the staff of the facility shall notify the resident's physician of any concerns noted by the person who submitted the report. The report must be reviewed and initialed by the administrator. Inspector Comments: Based on record review and interview, the Administrator failed to ensure a medication profile review, performed by a physician, pharmacist or registered nurse at least once every six months, was initialed by the Administrator for 7 of 15 sampled residents residing in the facility for longer than six months (Resident #7, #8, #9, #10, #1, #2 and #5). Findings include: Resident #7 Resident #7 was admitted to the facility on 10/22/20, with diagnosis including pulmonary embolism. Resident #7's file contained a medication reviews dated 08/09/22 and 11/02/22, however, the medication review lacked documented evidence of the Administrator's, or the Designee's signature indicating a review of the reports. Resident #8 Resident #8 was admitted to the facility on 03/22/16, with diagnoses including chronic obstructive pulmonary disease, osteoarthritis, and chronic back pain. Resident #8's file contained a medication reviews dated 08/09/22 and 11/02/22, however, the medication review lacked documented evidence of the Administrator's, or the Designee's signature indicating a review of the reports. Resident #9 Resident #9 was admitted to the facility on 06/09/17, with diagnoses including acute kidney failure, muscle weakness, and diabetes mellitus. Resident #9's file contained a medication reviews dated 08/09/22 and 11/02/22, however, the medication review lacked documented	0874	The Executive Director will review and initial/sign every page of each resident's review prior to filing in the binder going forward.	03/28/2023

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	evidence of the Administrator's, or the Designee's signature indicating a review of the reports. Resident #10 Resident #10 was admitted to the facility on 06/27/22, with diagnoses including chronic obstructive pulmonary disease, kidney disease and atrial fibrillation. Resident #10's file contained a medication reviews dated 11/02/22, however, the medication review lacked documented evidence of the Administrator's, or the Designee's signature indicating a review of the reports. Resident #1 Resident #1 was admitted to the facility on 10/28/21, with diagnoses including alcohol use disorder, cognitive dysfunction, alcohol related, hyperlipidemia and vitamin B-12 deficiency. Resident #1's clinical record documented six month medication profile reviews dated 05/22/22 and 11/02/22, however, the medication review lacked documented evidence of the Administrator's initials indicating a review of the reports. Resident #2 Resident #2 was admitted to the facility on 11/30/21, with diagnoses including hypertension and hypothyroidism. Resident #2's clinical record documented a six month medication profile review dated 11/02/22, however, the medication review lacked documented evidence of the Administrator's initials indicating a review of the reports. Resident #5 Resident #5 was admitted to the facility on 02/17/21, with diagnoses including hypertensive heart disease, atrial fibrillation, hyperlipidemia and hypothyroidism. Resident #5's clinical record documented six month medication profile reviews dated 05/22/22, 08/09/22, and 11/02/22, however, the medication review lacked documented evidence of the Administrator's initials indicating a review of the reports. On 01/17/23 at 1:59 PM, the Executive Director confirmed the six month medication profile reviews for the aforementioned residents lacked the initials of the Administrator indicting the reports had been reviewed and any recommendations had been acted upon. Severity: 1 Scope: 3			

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		A. BUILDING _____ B. WING _____	**02/15/2023**

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0876 SS= D	Medication Administration - NRS 449.0302 - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver 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: (a) Controlled substances or dangerous drugs only if the conditions prescribed in subsection 6 of NRS 449.0302 are met. (b) Insulin using an auto-injection device only if the conditions prescribed in NRS 449.0304 and NAC 449.1985 are met. Inspector Comments: Based on clinical record review, document review and interview, the facility failed to ensure an ultimate user agreement was completed timely for 1 of 15 sampled residents (Residents #4). Findings include: Resident #4 Resident #4 was admitted to the facility on 11/05/22 with diagnoses including recurrent falls, pelvic fracture, hypothyroidism and hypertension. Resident #4's clinical record documented an Ultimate User Agreement completed on 11/23/22, 16 days late. On 01/17/23 at 1:42 PM, the Caregiver confirmed Resident #4's Ultimate User Agreement was not completed timely. Severity: 2 Scope: 1	0876	The Executive Director will regularly audit resident files to ensure all Ultimate User agreements are updated based on the resident's medication management status. This will ensure residents going from self-management to the medication program or vice versa always have a current ultimate user agreement on file	03/28/2023
0878 SS= D	Medication/OTCS, Supplements, Change Order - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 5. An over-the-counter medication or a dietary supplement may be given to a resident only if the resident's physician has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician. The administration of over-	0878	The Executive Director and Resident Services Director hosted an in service with our medication technicians to review the change order sticker policy as well as Medication management best practices. During the in service several questions were answered. Graveyard shift med techs have been auditing the carts to ensure all change order stickers are placed appropriately and all PRN medication is always available in the carts. See attached training records	03/22/2023

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	the-counter medications and dietary supplements must be included in the record required pursuant to paragraph (b) of subsection 1 of NAC 449.2744. 6. Except as otherwise provided in this subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order; (2) Indicate on the container of the medication that a change has occurred; and (Previously Y 0879) (3) Note the change in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; (b) Within 5 days after the change is ordered, a copy of the order or prescription signed by the physician must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; and (c) If the label prepared by a pharmacist does not match the order or prescription written by a physician, the physician, registered nurse or pharmacist must interpret that order or prescription and, within 5 days after the change is ordered, the interpretation must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744. Inspector Comments: Resident #11 Resident #11 was admitted to the facility on 11/28/22, with a diagnosis including Parkinson's Disease. Resident #11's January 2023 MAR and physician's order dated 11/28/22, documented carbidopa-levodopa tablet 25-100 milligrams (mg), give two tablets by mouth two times a day for Parkinson's Disease. On 01/17/23 at 11:37 AM, during review of the resident's onsite medications, the label for carbidopa-levodopa tablet 25-100 mg, indicated to administer three times a day. The Med Tech confirmed the label was incorrect and there should have had a change sticker applied to indicate the physician's order had changed			

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	to two times a day. Severity: 2 Scope: 1 Based on clinical record review, document review and interview, the facility failed to ensure medications were available on site (Resident #2) and a change sticker was applied to a medication after a change in the physician's order (Resident #11) for 2 of 15 sampled residents. Findings include: Resident #2 Resident #2 was admitted to the facility on 11/30/21, with diagnoses including hypertension and hypothyroidism. Resident #2's January 2023 Medication Administration Record (MAR) documented albuterol sulfate HFA 10 micrograms, inhale two puffs every six hours as needed (PRN) for shortness of breath. The PRN medication was not available on site. On 01/17/23 at 1:32 PM, the Resident Services Director confirmed the facility lacked Resident #2's PRN albuterol sulfate HFA inhaler and verbalized it was still an active medication order.			
0895 SS= D	Administration of Medication Maintenance - NAC 449.2744 Administration of medication: Maintenance and contents of logs and records. (NRS 449.0302) 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall maintain: (b) A record of the medication administered to each resident. The record must include: (1) The type of medication administered; (2) The date and time that the medication was administered; (3) The date and time that a resident refuses, or otherwise misses, an administration of medication; and (4) Instructions for administering the medication to the resident that reflect each current order or prescription of the resident ' s physician. Inspector Comments: Based on observation, interview and clinical record review, the facility failed to ensure a Medication Administration Record (MAR) accurately reflected the correct dosage and number of tablets to be administered to a resident for 1 of 15 sampled residents	0895	The Executive Director and Resident Services Director hosted an in service with the medication technicians to review medication management best practices and encouraged triple checking the order, with the label and the MAR. See attached training records	03/22/2023

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

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	(Resident #12). Findings include: Resident #12 Resident #12 was admitted to the facility on 10/05/22, with diagnoses including memory loss, cerebrovascular disease, diabetes mellitus type II, and hypertension. A physician's order dated 11/24/22, documented cholecalciferol (vitamin D3) 25 micrograms (mcg)1,000-unit capsule (cap). Take 2,000 units by mouth every day for vitamin D deficiency. Resident #12's MAR for January 2023, documented vitamin D3 2,000-units/50 mcg soft gel, one capsule by mouth every day. On 01/17/23 at 11:15 AM, during review of Resident #12's medications, Resident #12 had vitamin D3 1,000 units/25 mcg soft gel capsules available for administration. The Medication Technician confirmed the dose of the available medication did not match the dosage of the medication as documented on the resident's MAR. On 01/17/23 at 12:38 PM, the Resident Services Director (RSD) confirmed Resident #12's physician's order for vitamin D3 and the vitamin D3 available for Resident #12 did not match the dosage and/or number of capsules to be given as documented on Resident #12's MAR. The RSD confirmed a resident's MAR entry should match the physician's order and the dosage of the medication available to the resident. Severity: 2 Scope: 1			

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0920 SS= D	Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 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. Medications 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 or herself without supervision may keep the resident ' s medication in his or her 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, document review, and interview, the facility failed to ensure resident medications were kept secured in the facility for 1 of 26 resident rooms with self-administering residents (Room #136). Findings include: On 01/17/23 at 10:12 AM, in Room #136, the resident's Keto apple cider vinegar capsules, 1000 microgram B12 capsules, and Hyland's nerve tonic were stored in an unlocked kitchen cabinet. The resident verbalized the corridor door was not always locked when the room was unoccupied. On 01/17/23 at 10:12 AM, the Community Sales Director confirmed the medications were kept unsecured and the medications should be stored in the locked cabinet in the resident's bathroom. Severity: 2 Scope: 1	0920	The unsecured medication referenced has since been secured and has been discussed with the resident. Housekeeping staff have been provided with a form to complete if they see unsecured medications in resident apartments, so that the Executive Director can correct the problem and remind the resident of the policy	03/22/2023

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

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0923 SS= D	Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 3. Medication, including, without limitation, any over-the-counter medication or dietary supplement, must be: (a) Plainly labeled as to its contents, the name of the resident for whom it is prescribed and the name of the prescribing physician; and (b) Kept in its original container until it is administered. Inspector Comments: Based on observation, interview, and clinical record review, the facility failed to ensure an over-the-counter medication was labeled with the resident's name and physician's name for 1 of 15 sampled residents (Resident #11). Findings include: Resident #11 Resident #11 was admitted to the facility on 11/28/22, with a diagnosis including Parkinson's Disease. Resident #11's January 2023 MAR and physician's order dated 11/29/22, documented Vitamin B1 100 milligrams (mg) tab, take one tab by mouth every day. On 01/17/23 at 11:39 AM, during review of the resident's onsite medications, the over-the-counter Vitamin B1 medication container was missing the resident's name and physician's name. The Med Tech confirmed the medication container was missing the resident's name and physician's name and it should have been on the over-the-counter container. Severity: 2 Scope: 1	0923	The Executive Director and Resident Services Director hosted an in service with the medication technicians to discuss and review proper medication labeling. During the in service the staff was allowed to practice with empty bottles and labels to ensure complete understanding. The resident services director will continue to audit the med carts to ensure all processes are being followed. Training records attached	03/22/2023
0936 SS= D	Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he or she 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	0936	All resident and employees TB tests have been added to Atria's internal tracker. In partnering with "Your Main Lab" we will ensure all reading dates and times are recorded as the time of placing and reading of a TB test.	03/28/2023

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	related to the resident, including, without limitation: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. Inspector Comments: Based on record review, document review, and interview, the facility failed to ensure 2 of 15 sampled residents met the requirements for timely tuberculosis (TB) testing in accordance with Nevada Administrative Code (NAC) 441A (Resident #2 and #3). Findings include: Resident #2 Resident #2 was admitted to the facility on 11/30/21, with diagnoses including hypertension and hypothyroidism. Resident #2's clinical record documented a QuantiFERON TB test read negative on 11/30/21. The resident's record lacked documented evidence of an annual TB for 2022. On 01/17/23 at 1:40 PM, the Resident Services Director confirmed Resident #2 lacked evidence of an annual TB test and verbalized TB testing was required annual for the safety of all residents. Resident #3 Resident #3 was admitted to the facility on 01/14/23 with diagnoses including non-traumatic acute subdural hemorrhage, hypothyroidism, muscle weakness and gastroesophageal reflux disease. Resident #3's clinical record documented a two step TB test with the first step read negative on 11/29/22 and the second step read negative on 12/06/22. The resident's record lacked documented evidence of the date and time the first step and second step TB testing was given. On 01/17/23 at 1:41 PM, the Resident Services Director confirmed Resident #3's TB testing information lacked the date the times given for both steps and verbalized the importance of complete TB testing for the safety of all residents. Severity: 2 Scope: 1			
0938 SS= D	Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be maintained for each resident of a residential	0938	Residents pre move in assessment was completed on 10/17/22 after a couple of move in delays, the resident physically arrived at the community on 11/5/22. The Executive Director discussed this instance with the Resident Services Director moving forward pre move in	03/21/2023

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	facility and retained for at least 5 years after he or she 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: (g) An evaluation of the resident ' s ability to perform the activities of daily living and a brief description of any assistance he or she needs to perform those activities. The facility shall prepare such an evaluation: (1) Upon the admission of the resident; (2) Each time there is a change in the mental or physical condition of the resident that may significantly affect his or her ability to perform the activities of daily living; and (3) In any event, not less than once each year. Inspector Comments: Based on clinical record review, document review and interview, the facility failed to ensure an admission Activities of Daily Living (ADL) Assessment was completed timely for 1 of 15 sampled residents (Resident #4). Findings include: Resident #4 Resident #4 was admitted to the facility on 11/05/22 with diagnoses including recurrent falls, pelvic fracture, hypothyroidism and hypertension. Resident #4's clinical record documented an initial ADL assessment completed on 11/07/22, 2 days late. On 01/17/23 at 1:42 PM, the Resident Services Director confirmed Resident #4's initial ADL assessment was late and verbalized ADL assessments were required to be completed upon admission to establish the resident's care plan needs. The facility policy titled "Assessments - Move-In, 30-day, Routine or Change of Condition," revised 09/28/22, documented the Executive Director and Resident Services Director are responsible to ensure assessments are completed accurately and timely. Severity: 2 Scope: 1		assessments versus physical move in will not exceed fourteen days. If resident will move in beyond fourteen days a new assessment will be completed.	
1540	Cultural Competency Training - R016-20	1540	Atria Summit Ridge is now compliant in	03/28/202

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SS= F	Section 14.1 1. Pursuant to subsection 1 of NRS 449.103, within 30 business days after the course or program is assigned a course number by the Division pursuant to section 18 of this regulation or within 30 business days of any agent or employee being contracted or hired, whichever is later, and at least once each year thereafter, a facility shall conduct training relating specifically to cultural competency for any agent or employee of the facility who provides care to a patient or resident of the facility so that the agent or employee may: (a) More effectively treat patients or care for residents, as applicable; and (b) Better understand patients or residents who have different cultural backgrounds, including, without limitation, patients or residents who fall within one or more of the categories in paragraphs (a) to (f), inclusive, of subsection 1 of NRS 449.103. Inspector Comments: Based on personnel record review and interview, the facility failed to ensure cultural competency training was completed timely for 4 of 7 sampled employees required to obtain cultural competency training (Employee #4, #11, #12, and #13). Findings include: Employee #4 Employee #4 was hired as Resident Services Coordinator with a start date of 09/05/22. The personnel record for Employee #4 contained a cultural competency training certificate dated 11/15/22, 41 days after the required 30 days. Employee #11 Employee #11 was hired as Resident Services Coordinator with a start date of 07/07/22. The personnel record for Employee #11 contained a cultural competency training certificate dated 11/15/22, 101 days after the required 30 days. Employee #12 Employee #12 was hired as Resident Services Coordinator with a start date of 06/21/22. The personnel record for Employee #12 contained a cultural competency training certificate dated 11/15/22, 117 days after the required 30 days. Employee #13 Employee #13 was		Cultural Awareness. The Executive Director has created a tracker to ensure all employees receive the training within thirty days of employment and annual thereafter.	3

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	hired as Resident Services Coordinator with a start date of 12/22/21. The personnel record for Employee #13 contained a cultural competency training certificate dated 11/15/22, 137 days after the required date of completion. On 01/17/23 at 12:32 PM, the Executive Director provided the Attestation of Compliance form, signed and dated 01/17/23, confirming the Corporate Executive Director had conducted a thorough review of the personnel records to determine compliance and any noncompliance found. The Corporate Executive Director verbalized attesting to the accuracy of the Personnel Checklist Form self-attestation. Severity: 2 Scope: 3			
1700 SS= D	Annual Assessment of History of Each Resident - NRS 449.1845 Administrator of residential facility for groups to conduct annual assessment of history of each resident and cause provider of health care to conduct certain examinations and assessments; placement based on assessment. 1. The administrator of a residential facility for groups shall: (a) Annually cause a qualified provider of health care to conduct a physical examination of each resident of the facility; (b) Annually conduct an assessment of the history of each resident of the facility, which must include, without limitation, an assessment of the condition and daily activities of the resident during the immediately preceding year; and (c) Cause a qualified provider of health care to conduct an assessment of the condition and needs of a resident of the facility to determine whether the resident meets the criteria prescribed in paragraph (a) of subsection 2: (1) Upon admission of the resident to the facility; and (2) If a physical examination, assessment of the history of the resident or the observations of the administrator or staff of the facility, the family of the resident or another person who has a relationship with the resident indicate that: (I) The resident may meet those criteria; or (II) The condition of the resident	1700	Initial Physicians report was completed and uploaded to Atria's internal tacking system within the required timeframe dated 6/8/17 from the physician, with a move in date of 6/9/17. The Executive Director walked the staff through how to find required information/documentation for state audits within Atria's intranet for future surveys	03/21/2023

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ATRIA SUMMIT RIDGE	**4880 SUMMIT RIDGE DRIVE, 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
	has significantly changed. 2. If, as a result of an assessment conducted pursuant to paragraph (c) of subsection 1, the provider of health care determines that the resident: (a) Suffers from dementia to an extent that the resident may be a danger to himself or herself or others if the resident is not placed in a secure unit or a facility that assigns not less than one staff member for every six residents, any residential facility for groups in which the resident is placed must meet the requirements prescribed by the Board pursuant to subsection 2 of NRS 449.0302 for the licensing and operation of residential facilities for groups which provide care to persons with Alzheimer's disease or other severe dementia. (b) Does not suffer from dementia as described in paragraph (a), the resident may be placed in any residential facility for groups. 3. As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031. (Added to NRS by 2019, 2594) Inspector Comments: Based on record review and interview, the facility failed to obtain a Standard Physician Assessment and Placement Determination for 1 of 15 residents (Resident #9). Findings include: Resident #9 Resident #9 was admitted to the facility on 06/09/17, with a diagnoses including acute kidney failure, muscle weakness and diabetes mellitus Resident #9's record lacked documented evidence a Standard Physician Assessment and Placement Determination had been completed. On 01/17/23 at 1:47 PM, the Resident Services Director confirmed a Standard Physician Assessment and Placement Determination had not been completed for Resident #9. Severity: 2 Scope: 1			