Accepted for 10/29/08 DBagnato

Bureau of Licensure and Certification

PRINTED: 09/16/200
FORM APPROVE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVN413AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED 09/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA SUMMIT RIDGE	4880 SUMMIT RIDGE DR RENO, NV 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) COMPLETE DATE
Y 000	Initial Comments This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility from 9/2/08 to 9/4/08. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for 85 Residential Facility for Group beds for elderly and disabled persons, 63 Category I and 22 Category II residents. The census at the time of the survey was 74. Fifteen resident files were reviewed and eleven employee files were reviewed. One discharged resident file was reviewed. The following deficiencies were identified:	Y 000	Initial Comments The preparation and submission of this plan of correction does not constitute, nor shall it be deemed to constitute, an admission of fault or liability on the part of the Facility or agreement by the Facility as to the truth or accuracy of the facts alleged or the conclusions drawn in the Statement of Deficiencies based upon the survey completed 9/04/08.	
Y 103 SS=F	449.200(1)(d) Personnel File - NAC 441A NAC 449.200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (d) The health certificates required pursuant to chapter 441A of NAC for the employee. This Regulation is not met as evidenced by: NAC 441A.375 Medical facilities, facilities for the dependent and homes for individual residential care: Management of cases and suspected cases; surveillance and testing of employees; counseling and preventive treatment. 3. Before initial employment, a person employed in a medical facility, a facility for the dependent or a home for individual residential care shall have	Y 103	RECEIVED OCT 01 2008 BUREAU OF LICENSURE AND CERTIFICATION CARSON CITY, NEVADA	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE EXECUTIVE DIRECTOR 9/30/08

SIGN HERE

STATE FORM 6899 ED4C11

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Y 103	Continued From page 1 a: (a) Physical examination or certification from a licensed physician that the person is in a state of good health, is free from active tuberculosis and any other communicable disease in a contagious stage; and (b) Tuberculosis screening test within the preceding 12 months, including persons with a history of bacillus Calmette-Guerin (BCG) vaccination. If the employee has only completed the first step of a 2-step Mantoux tuberculin skin test within the preceding 12 months, then the second step of the 2-step Mantoux tuberculin skin test or other single-step tuberculosis screening test must be administered. A single annual tuberculosis screening test must be administered thereafter, unless the medical director of the facility or his designee or another licensed physician determines that the risk of exposure is appropriate for a lesser frequency of testing and documents that determination. The risk of exposure and corresponding frequency of examination must be determined by following the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. Based on record review on 9/2/08, the facility did not ensure 3 of 6 employees who had worked at the facility for more than 12 months met the requirements for annual tuberculosis (TB) tests. Findings include: Employee #7 was hired on 2/7/07 and completed an initial two-step TB test on 2/9/07. The employee's annual TB test for 2008 was not initiated until 8/3/08, six months late. The employee completed a second step of the TB test on 8/14/08.	Y 103	Tag Y 103 Corrective Action: The tuberculosis screening tests for Employees #7, 8, and 10 have been administered and completed. Evidence of the second step of the 2-step Mantoux test for Employee #8 is attached hereto as Exhibit 1. Identification of Others Potentially Affected: The Facility conducted a review of all employee files to confirm that timely tuberculosis testing has occurred and notice was provided to employees to ensure timely testing. Systematic Changes to Prevent Recurrence: The Facility has implemented a tracking system to monitor hire dates for all employees, including new staff members as they are hired, to ensure timely TB testing. A sample page of the tracking form is attached hereto as Exhibit 2. Monitoring: The Facility Community Business Director and the Executive Director will periodically, and no less than monthly, monitor and track the timely completion of annual TB testing by Facility employees. Date of Completion: 9/05/2008	ok DB

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Y 103	Continued From page 2 Employee #8 was hired on 4/5/02. The employee's 2007 TB test was initiated on 8/13/07 and completed on 8/16/07. The employee's annual TB test for 2008 was late and was not initiated until 8/28/08 and was read on 8/30/08. The administrator reported the employee had started a second step. Employee #10 was hired on 1/9/06. The employee's annual TB test for 2007 was initiated on 1/8/07 and completed on 1/10/07. The employee's annual TB test for 2008 was not initiated until 7/16/08, six months late. The employee completed the second step of the TB test on 7/25/08. Severity: 2 Scope: 3	Y 103	Tag Y 250 Corrective Action: The Facility Food Service Director caused the kitchen area, walk-in refrigerator and freezer to be cleaned of food residue and wrappers so as to allow for the sanitary preparation of food. The Food Service Director caused the concentration of Quaternay sanitizing solution to be corrected as of 9/4/2008. Identification of Others Potentially Affected: Although residents of the Facility could have been adversely affected by these deficient practices, no residents were in fact adversely affected and the corrective measures taken will ensure that the practices will not recur.	
Y 250 SS=C	449.217(1) Kitchens NAC 449.217 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. This Regulation is not met as evidenced by: Based on observation, interview and record review on 9/2/08, the facility did not ensure its kitchen was clean and allowed for the sanitary preparation of food.	Y 250	Systematic Changes to Prevent Recurrence: The Facility Food Service Director implemented a cleaning schedule as of 9/5/2008, an example of which is attached hereto as Exhibit 3, that will require additional cleaning of the kitchen area floors at more frequent intervals. The Food Service staff received in-service training as of 9/4/2008 regarding the proper levels for all sanitizing solutions and the topic will be included in future training for the Food Service department. Monitoring: The Facility Food Service Director and the lead chef for each shift will monitor the daily cleaning of the kitchen areas and the concentration levels of the sanitizing solutions Completion Date: 9/05/2008	

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Y 250	Continued From page 3 Findings include: A tour of the kitchen at 10:00 AM revealed the following: 1. The floors in the kitchen area, walk-in refrigerator and freezer were dirty and needed to be cleaned of food residue and wrappers. 2. The concentration of the Quaternary sanitizing solution in the dishrag bucket was high, with a reading of 400 ppm. (The manufacturer's recommendation is 150-200 ppm.) Severity: 1 Scope: 3	Y 250	Tag Y 251 Corrective Action: The box of spoiled food items was disposed of immediately following its discovery. The Food Service Director caused a thorough inspection to be made of all food stored in the walk-in refrigerator and confirmed that no other spoiled food items were present. Identification of Others Potentially Affected: Although residents of the Facility could have been adversely affected by these deficient practices, no residents were in fact adversely affected and the corrective measures taken will ensure that the practices will not recur.	AC DB
Y 251 SS=D	449.217(2) Storage of Food NAC 449.217 2. Perishable foods must be refrigerated at a temperature of 40 degrees Fahrenheit or less. Frozen foods must be kept at a temperature of 0 degrees or less. This Regulation is not met as evidenced by: Based on observation and interview on 9/2/08, the facility did not ensure that spoiled food was discarded in a timely manner. Findings include: An inspection of the kitchen's walk-in refrigerator at 10:00 AM revealed a box of moldy lemons, soft cucumbers, and a bruised melon. The kitchen supervisor stated that she planned to	Y 251	Systematic Changes to Prevent Recurrence: The Food Service Director implemented a new practice of disposing of any questioned food item immediately rather than collecting them throughout the day for a one-time per day disposal. Monitoring: The Facility Food Service Director and the lead chef for each shift will monitor the continuing inspection and disposal, if needed, of food items stored in the walk-in refrigerator. Completion Date: 9/05/2008	

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Y 251	Continued From page 4 discard these items soon. Severity: 2 Scope: 1	Y 251	Tag Y434	
Y 434 SS=B	449.229(3) Emergency Drills NAC 449.229 3. A drill for evacuation must be performed monthly on an irregular schedule, and a written record of each drill must be kept on file at the facility for not less than 12 months after the drill. This Regulation is not met as evidenced by: Based on record review on 9/2/08, the facility did not ensure monthly evacuation drills were conducted on an irregular schedule for the past 6 of 12 months. Findings include: The facility did not have documentation that fire drills had been conducted for August, July, June, and May of 2008. The facility did not have documentation that fire drills had been conducted for December and November of 2007. Severity: 1 Scope: 2	Y 434	Corrective Action: The Facility caused documentation of the emergency drills conducted on 5/8/08, 6/9/08, and 8/4/08 to be faxed to the Bureau of Licensure and Certification as of 9/4/08. The Facility was unable to locate documentation of the emergency drills conducted in 11/07 and 12/07. Identification of Others Potentially Affected: Although residents of the Facility could have been adversely affected by this deficient practice, no residents were in fact adversely affected and the corrective measures taken will ensure that the practice will not recur. Systematic Changes to Prevent Recurrence: The Maintenance Director and the Executive Director of the Facility have implemented a policy of conducting monthly evacuation drills on an irregular schedule and maintaining a written record of such drills. Monitoring: The Facility Executive Director will monitor the fire drill logs on a monthly basis to ensure compliance with the regulatory requirements. Completion Date: 9/05/2008	
Y 444 SS=C	449.229(9) Smoke Detectors NAC 449.229 9. Smoke detectors must be maintained in proper operating conditions at all times and must be tested monthly. The results of the tests pursuant to this subsection must be recorded and	Y 444		

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Y 444	Continued From page 5 maintained at the facility. This Regulation is not met as evidenced by: Based on record review on 9/2/08, the facility did not ensure smoke detectors were tested 6 of the past 12 months. Findings include: The smoke detector testing log revealed facility smoke detectors were not checked during the months of February, March, May, June, July and August of 2008. The facility had a complete electronic fire alarm system that had been tested and certified according to regulations, but the facility had added additional battery operated smoke detectors to some resident rooms. These smoke detectors lacked documentation that they had been tested and maintained properly. Severity: 1 Scope: 3	Y 444	Tag Y 444 Corrective Action: The Facility prepared a list of the location of all battery-operated smoke detectors and inspected, tested, and documented the operation of each detector. Identification of Others Potentially Affected: Although residents of the Facility could have been adversely affected by this deficient practice, no residents were in fact adversely affected and the corrective measures taken will ensure that the practice will not recur. Systematic Changes to Prevent Recurrence: The Maintenance Director of the Facility implemented a policy of conducting monthly inspections of the battery-operated smoke detectors and maintaining a written record of such testing and operation. Monitoring: The Facility Maintenance Director will monitor the inspection and documentation of such testing of the battery-operated smoke detectors on a monthly basis to ensure compliance with the regulatory requirements. Completion Date: 9/05/2008	
Y 876 SS=B	449.2742(4) NRS 449.037 NAC 449.2742 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 449.037 are met. This Regulation is not met as evidenced by: NRS 449.037(6). The Board shall adopt separate regulations regarding the assistance which may be given pursuant to NRS 453.375 and 454.213	Y 876		

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Y 876	Continued From page 6 to an ultimate user of controlled substances or dangerous drugs by employees of residential facilities for groups. NRS 453.375 Authority to possess and administer controlled substances. A controlled substance may be possessed and administered by the following persons: 6. An ultimate user or any person whom the ultimate user designates pursuant to a written agreement. NRS 454.213 Authority to possess and administer dangerous drug. A drug or medicine referred to in NRS 454.181 to 454.371, inclusive, may be possessed and administered by: 10. An ultimate user or any person designated by the ultimate user pursuant to a written agreement. Based on record review on 9/2/08, the facility did not ensure it had obtained signed written agreements to assist 2 of 14 residents with their medications. Findings include: Signed ultimate user agreements were not found in the files of Residents #9 and #12. This is a repeat deficiency for the 9/20/07 annual survey. Severity: 1 Scope: 2	Y 876	Tag Y 876 Corrective Action: The Facility caused Ultimate User Agreements to be executed by Residents #9 and #12, copies of which are attached hereto as Exhibits 4 and 5. The Facility inspected all resident files to confirmthat executed Ultimate User agreements existed for all residents receiving assistance from the Facility with regard to medications. Identification of Others Potentially Affected: Although residents of the Facility could have been adversely affected by this deficient practice, no residents were in fact adversely affected and thecorrective measures taken will ensure that the practice will not recur. Systematic Changes to Prevent Recurrence: The Maintenance Director of the Facility implemented a policy of conducting monthly inspections of the battery-operated smoke detectorsand maintaining a written record of such testing and operation. Monitoring: The Facility Community Business Director will periodically monitor the resident files to confirm that the file of each resident receiving assistance from the Facility in the administration of medications contains an executed Ultimate User agreement. Completion Date: 9/05/2008	OK DB
Y 944 SS=A	449.2749(2) Resident File / Discharge NAC 449.2749 2. The document required pursuant to paragraph (j) of subsection 1 must indicate the location to which the resident was transferred or the person in whose care the resident was discharged. If the resident dies while a resident of the facility, the document must include the time and date of the death and the dates on which the person responsible for the resident was contacted to	Y 944		

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Y 944	Continued From page 7 inform him of the death. This Regulation is not met as evidenced by: Based on record review and interview on 9/2/08, the facility did not have discharge documentation regarding 1 of 1 residents who had left the facility. Findings include: The administrator provided the closed file of Resident #16 for review. The administrator reported the resident gave 30-day notice to the facility and moved out of state in March 2008. The facility did not have a discharge document indicating when the resident left the facility or any other information concerning the discharge. Severity: 1 Scope: 1	Y 944	Tag Y 944 Corrective Action: The Facility will complete a Discharged Resident Information form for each resident discharged from the Facility, indicating the location to which the resident was transferred or the person into whose care the resident was discharged, or in the case of death of the resident, the time and date of death and the date of notice given to the responsible party. A copy of the Discharged Resident Information form is attached hereto as Exhibit 6. Identification of Others Potentially Affected: Although residents of the Facility could have been adversely affected by this deficient practice, no residents were in fact adversely affected and the corrective measures taken will ensure that the practice will not recur. Systematic Changes to Prevent Recurrence: The Discharged Resident Information form will be included on the Resident File Information Checklist and completed for each transferring resident when move-out documentation is completed. Monitoring: The Facility Community Business Director will periodically monitor the resident files to confirm that the file of each resident transferring from the Facility contains a completed Discharged Resident Information form. Completion Date: 9/05/2008	

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