

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4241	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2020
NAME OF PROVIDER OR SUPPLIER A SUMMERDALE HOMES AT RIATA, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 14315 RIATA CIRCLE, RENO, NEVADA ,89521		
(X4) ID PREFIX TAG 0000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG 0000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as the result of a follow-up State Licensure COVID-19 Infection Control and Prevention Plan Survey conducted in your facility on 10/01/20. This State Licensure survey was conducted by the Division of Public and Behavioral Health in accordance with NAC 449, Residential Facility for Groups. The facility is licensed for eight Residential Facility for Group beds for elderly and disabled persons, Category II residents. The census at the time of the survey was eight. There were no positive or presumptive Covid-19 residents or staff at the time of the survey. The facility utilized the front entrance as the main access point for all non-essential visitors. The entry way had a table with disinfectant spray, hand sanitizer, facemasks, and gloves available to visitors. The Caregiver provided entry temperature screening, a written questionnaire, and required the visitor to wear a facemask, spray the bottoms of shoes, and use hand sanitizer. All residents were observed to be socially distanced in the common area. Staff observations included the use of masks and gloves with resident care, reminders to residents to social distance in the common areas, and the use of masks and gloves during their daily routines. The facility was cleaned with Lysol disinfecting products daily with high-touch areas cleaned every two hours. The facility did not allow any new admissions since the Covid-19 outbreak. An interview conducted with the Caregiver revealed the facility maintained an adequate supply of the following personal protective equipment (PPE): disposable gowns, gloves, faceshields, surgical masks, and N-95 masks. One facility staff member had completed the N-95 Fit testing and document copies were available for review. The facility provided continuing education on Infection Prevention and Control Training to staff members through weekly meetings that included a review of Centers for Disease Control guidelines. A review of the facility's Infection Control and			

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 Name:
REPRESENTATIVE'S SIGNATURE

Title:

Date:

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	Prevention Plan revealed the facility had the following components documented and ready for implementation: - A verbal interview with Administrator describing implementation of the plan. - Visitor entry and facility screening practices - An Emergency Staffing Plan if a staff member tested positive - A plan if a resident tested positive - Access to or inventory of Personal Protective Equipment (PPE) - Staff training on the proper use of PPE to include donning and doffing - Staff Fit Tests for N-95 masks - Respirator Program - Identification and response to residents with suspected or confirmed COVID-19 - New Admissions or Readmissions with an unknown COVID-19 status - Required notifications The findings and conclusions of any investigation by the Health Division 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. No regulatory deficiencies were identified.			