

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4234	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/24/2021
NAME OF PROVIDER OR SUPPLIER SAINT PAUL HOME CARE 2		STREET ADDRESS, CITY, STATE, ZIP CODE 4900 KOENIG ROAD, RENO, NEVADA ,89506		
(X4) ID PREFIX TAG 0000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a State Licensure annual grading survey conducted in your facility on 05/24/21. 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 10 Residential Facility for Group beds for elderly and disabled persons and/or persons with intellectual disability, with one bed for low income, three Category 1 and seven Category II residents. The census at the time of the survey was ten. Ten resident files were reviewed and five employee files were reviewed. The facility received a grade of A. 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:	ID PREFIX TAG 0000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
0178 SS= D	Health & Sanitation - Maintain Int/ext - NAC 449.209 Health and sanitation. (NRS 449.0302) 5. The administrator of a residential facility shall ensure that the premises are clean and that the interior, exterior and landscaping of the facility are well maintained. Inspector Comments: Based on observation and interview, the facility failed to ensure a window in a resident's bathroom was in good repair. Findings include: On 05/24/21 at 10:43 AM, in the master bedroom bathroom, the window appeared to have a BB gun pellet sized hole, with cracks dispersing from the hole. On 05/24/21 at 10:45 AM, the Caregiver verbalized discovering the broken window recently and the caregiver thought the broken window was caused by someone possibly shooting a BB gun toward the window. The Caregiver confirmed the window was broken. Severity: 2 Scope: 1	0178	The bathroom window in the master bedroom has been replaced as shown in the attachment. The facility administrator will ensure that all damage done to the facility that could constitute a hazard is repaired in a timely manner.	06/08/202 1

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 REPRESENTATIVE'S SIGNATURE	Name: EVANGELINE BELTEJAR	Title: Owner	Date: 08/24/2021
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