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 _____	**08/09/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT PAUL HOME CARE 2	**4900 KOENIG ROAD, RENO, NEVADA ,89506**

(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: This Statement of Deficiencies was generated as a result of a complaint investigation initiated at your facility on 08/09/21. This State investigation was conducted by the Division of Public and Behavioral Health in accordance with NAC 449, Residential Facility for Groups. The census at the time of investigation was nine. The sample size was ten. Complaint #NV00064551 with the following allegations: Allegation #1: Family worried they would be denied entry into the facility if they did not call first could not be substantiated due to lack of evidence. Allegation #2: Resident not being administered Trazodone as prescribed could not be substantiated due to lack of evidence. Allegation #3: Resident diabetic diet not being followed could not be substantiated due to lack of evidence. Allegation #4: Facility was kept locked during business hours could not be substantiated due to lack of evidence. Allegation #5: Resident was told they were not allowed to go outside and smoke could not be substantiated due to lack of evidence. The investigation into the allegations included: Observation of entry points into the facility being locked and residents' activities within the facility. Interviews were conducted with the Owner, a Caregiver and a resident. Document review included Medication Administration Records, visitation logs, history and physicals, food menus, resident rights, admission records, resident house rules, physician orders and ultimate user agreements. Facility document review included the grievance policy. 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 investigation, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. No regulatory deficiencies	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: Title: Date:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	were identified. No further action is necessary. Please retain a copy of this report for your records.			