Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	4234	A. BUILDING _____ B. WING _____	04/27/2023

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 State Licensure mandatory annual survey conducted at your facility on 04/27/23. This survey was conducted by the Division of Public and Behavioral Health in accordance with NAC 449, Residential Facility for Groups. The facility was 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 six Category II residents. The census at the time of the survey was nine. Nine resident files were reviewed, and four 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:	0000		
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 the hallway bathroom lights were adequately functioning. Findings include: On 04/27/23 at 10:18 AM, in main hallway resident bathroom, one light bulb in the toilet area and one bulb in the vanity were burnt out and not turning on. On 04/27/23 at 10:20 AM, the Caregiver confirmed the light bulbs had burnt out, and he had not had time to replace each burnt out bulb. The Caregiver confirmed that the light bulbs should have been changed right away, as it is a safety hazard. Severity: 2 Scope: 1	0178	The light bulbsin the main resident bathroom toilet area and in the vanity were replaced. The facility administrator confirmed they arenow functioning properly. The facilityadministrator will monitor the facility lights to ensure that all lights areworking properly and are immediately replaced upon notice of failure to avoidthe safely hazard of inadequate lighting.	06/30/2023

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-DIFUNTORUM	Title: Owner	Date: 06/30/2023

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0252 SS= D	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, and interview the facility failed to ensure 1) food in the refrigerator was covered, 2) food was labeled upon placing in the refrigerator and 3) to discard expired food. Findings include: On 04/27/23 at 9:04 AM, located in the refrigerator was a large plastic bin containing leftover soup, and a large container of pasta salad. Both bins were not labeled nor covered. On 04/27/23 at 9:11 AM, the Caregiver confirmed the bin containing leftover soup and the container of pasta salad were not labeled and not covered. The Caregiver explained all food was required to be accurately labeled upon opening and placing in the refrigerator, all food had to be covered and expired food items were to be discarded three days after the preparation date. Severity: 2 Scope: 1	0252	Employees of the facility have beenreprimanded and given re-training by the facility administrator on theimportance of food handling and safety. They were especially reminded of theimportance of proper food storage, including the proper coverage and labeling ofthe food. The facility administratorwill monitor the kitchen and cooking area of the facility for food handlingviolations.	06/30/2023

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0859 SS= D	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 record review, the facility failed to ensure a physical examination including a review of systems was completed annually for 1 of 9 residents (Resident #9). Findings include: Resident #9 Resident #9 was admitted to the facility on 03/04/22 with a diagnosis of diabetes. Resident #9's record documented an initial physical dated 03/22/22. The resident's record lacked documented evidence of an annual physical examination with a review of systems for 2023. On 04/27/23 at 11:01 AM, the Caregiver confirmed an annual physical examination with a review of systems was not completed for Resident #9 in 2023. Severity: 2 Scope: 1	0859	A physicianprogress note was requested and received by the facility for resident #9. Attached is theprogress note which indicates a visit with his primary care provider on 12/12/2022. The facility administratorwill utilize a resident file checklist to ensure that all residents receive anannual physical examination on or prior to the anniversary date of their lastphysical examination and prior to admission to the facility.	06/30/2023

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0920 SS= F	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 and interview, the facility failed to ensure resident medications were kept secured in the facility. Findings include: On 04/27/23 at 10:25 AM, the door to the medication cabinet was open and unlocked. Inside of the medication cabinet there were all residents medications open and exposed located in the main hallway, with no supervision of the cabinet by staff. On 04/27/23 at 10:28 AM, the Caregiver explained the medication cabinet stored all resident medications and the door to the medication cabinet should be locked at all times. The Caregiver verbalized leaving medications unsecured was dangerous to all residents in the facility, if residents took medications not prescribed to the specific resident. Severity: 2 Scope: 3	0920	Employees of the facility have been reprimanded and givenre-training by the facility administrator on the importance of medication managementand safety. They were especially reminded of the importance of propermedication storage and how the medication cabinet should always remain lockedwhen not supervised. The facilityadministrator will monitor caregivers administering medications for compliance.	06/30/2023