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 _____	**09/27/2023**

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: Citation Text for Tag 0000, Regulation I49N Ortega, Esther This Statement of Deficiencies was generated as a result of a complaint investigation conducted in your facility on 09/27/23. This investigation 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 I and six Category II residents. The census at the time of investigation was nine. Nine resident records and four employee records were reviewed. The facility received a grade of A. There was one complaint investigated: Complaint #NV00069492 with the following allegations could not be substantiated due to a lack of evidence: Allegation #1: the facility did not serve hot meals and meals served had poor nutritional value. Allegation #2: a resident's toilet did not flush. Allegation #3: the facility had a lack of paper towels and soap in resident bathrooms. Allegation #4: the facility had a lack of linens. The investigation into the allegations included: Observations of residents in resident rooms, living room, dining area, and kitchen, resident food in two refrigerators, two freezers, two pantries, operation of kitchen equipment, posted menus, and residents eating lunch. Interviews were conducted with two residents including the resident of concern, the Owner/Caregiver, and a Caregiver/Cook. Reviewed nine resident records including the resident of concern to include diagnoses and diet orders. 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	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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	federal, state, or local laws. No regulatory deficiencies were identified. No further action is necessary. Please retain a copy of this report for your records.			