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 _____	09/26/2024

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 annual survey conducted at your facility on 09/26/2024. 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 ten 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 the survey was ten. Ten resident files were reviewed, and five employee files were reviewed. The facility received a grade of B. 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		

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0172 SS= F	Health And Sanitation-Garbage - NAC 449.209 Health and sanitation. (NRS 449.0302) 2. Containers used to store garbage outside of the facility must be kept reasonably clean and must be covered in such a manner that rodents are unable to get inside the containers. At least once each week, the containers must be emptied and the contents of the containers must be removed from the premises of the facility. 3. Containers used to store garbage in the kitchen and laundry room of the facility must be covered with a lid unless the containers are kept in an enclosed cupboard that is clean and prevents infestation by rodents or insects. Containers used to store garbage in bedrooms and bathrooms are not required to be covered unless they are used for food, bodily waste or medical waste. Inspector Comments: Based on observation and interview, the facility failed to ensure a garbage can was covered and a garbage bag was not overflowing the top of the garbage can. Findings include: On 09/26/2024 at 11:15 AM, a garbage can was located on the back patio of the house. The garbage can lacked a lid and a bag of garbage overflowed the top of the garbage can. On 09/26/2024 at 11:15 AM, the Admissions and Office Manager confirmed the garbage can lacked a lid and could not close to prevent rodent and pest infestations. Severity: 2 Scope: 3	0172	1. Facility contractor was immediately contacted anddownstairs garbage can was immediately removed from the premises and all othergarbage cans inspected to ensure can close properly to avoid pest. 2. Garbage can checks have been included during the weeklyinspection of repairs and housekeeping needed at facility. Caregivers retrainedin proper protocol to notify facility owner and contractor immediately uponnoticing these items. 3.To ensure that the deficiency does not recur, thedownstairs garbage can have been removed as it is an easy to miss area. The caregiverswill include outside garbage cans as part of the routine weekly buildinginspections. The facility administrator will review the results of theinspections to ensure ongoing compliance. Any unfit or not secured garbagemethods identified during inspections will be documented and correctedimmediately. 4. The facility owner will be responsible for ensuring theplan of correction is implemented. 5.Corrected on 10/15/2024. 6. All relevant documents/photos uploaded. 7.To identify and correct other areas that may be affectedby this issue, a facility-wide audit will be conducted to check all garbagecans for the presence and condition of unable to close. Any cans or easy tomiss garbage areas lacking ability to close will be corrected immediately.Additionally, all caregivers will be instructed to report any notice of thisissue during their daily rounds, and the maintenance staff will address anyreports promptly	10/15/2024

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0179 SS= D	Health & Sanitation - Screens - NAC 449.209 Health and sanitation. (NRS 449.0302) 6. All windows that are capable of being opened in the facility and all doors that are left open to provide ventilation for the facility must be screened to prevent the entry of insects. Inspector Comments: Based on observation and interview, the facility failed to ensure all windows capable of being opened in the facility to provide ventilation for the facility were screened to prevent the entry of insects. Findings include: On 09/26/2024, the following resident rooms lacked screens or had defective screens. - at 11:11 AM, a window in Resident #4's room had a screen with two holes in it. - at 11:14 AM, a window in Resident #9's and Resident #10's shared room lacked a screen. On 09/26/2024 between 11:11 AM and 11:14 AM, the Admissions and Office Manager confirmed the window screen concerns. Severity: 2 Scope: 1	0179	1. Facility contractor was immediately contacted and allscreens placed or replaced at all windows. 2. The window screens have been included during the monthlycontractor inspection of repairs needed at facility. Caregivers retrained inproper protocol to notify facility owner and contractor immediately uponnoticing these items. 3.To ensure that the deficiency does not recur: Thecontractor will include window screen inspections as part of the routinemonthly building inspections. The facility administrator will review theresults of the monthly inspections to ensure ongoing compliance. Any missing ordamaged screens identified during inspections will be documented and correctedimmediately. 4. The facility owner will be responsible for ensuring theplan of correction is implemented. 5. Corrected on 10/15/2024. 6. All relevant documents/photos uploaded. 7.To identify and correct other areas that maybe affected by this issue, a facility-wide audit will be conducted to check allwindows for the presence and condition of screens. Any windows found lackingscreens or with damaged screens will be corrected immediately. Additionally,all caregivers will be instructed to report missing screens during their dailyrounds, and the maintenance staff will address any reports promptly	10/15/2024

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0876 SS= D	Medication Administration - NRS 449.0302 - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 4. Except as otherwise provided in this subsection, a caregiver shall assist in the administration of medication to a resident if the resident needs the caregiver's assistance. A caregiver may assist the ultimate user of: (a) Controlled substances or dangerous drugs only if the conditions prescribed in subsection 6 of NRS 449.0302 are met. (b) Insulin using an auto-injection device only if the conditions prescribed in NRS 449.0304 and NAC 449.1985 are met. Inspector Comments: Based on record review and interview, the Administrator failed to ensure an Ultimate User Agreement was dated upon resident admission for 1 of 10 sampled residents (Resident #3). Findings include: Resident #3 Resident #3 was admitted to the facility on 08/10/2024 with diagnoses including hypertension, depression, and chronic obstructive pulmonary disease. Resident #3's Ultimate User Agreement was signed by the resident, however, the document was not dated. On 09/26/2024 at 1:05 PM, the Admissions and Office Manager confirmed Resident #3's record lacked a dated Ultimate User Agreement. Severity: 2 Scope: 1	0876	1. Ultimate UserAgreements are completed for Residents #3. This agreement will clarify whetherthese residents can self-administer their medications or if facility staff needto manage the medications on their behalf. Documentation: The complete UltimateUser Agreements will be placed in each resident's clinical record and a copyprovided to the resident or their representative. 2. Addressed the facility's admission procedures to includethe completion of an Ultimate User Agreement as part of the initial intakeprocess for all new residents. Staff Training: Conduct training sessions forall staff to emphasize the importance of the Ultimate User Agreement inmedication administration and management, ensuring compliance with updatedadmission procedures. Ultimate user agreement has been included in the residentchecklist. 3. Regular Audits: The Facility Administrator, inconjunction with the management staff, will conduct monthly audits of residentfiles to verify the presence of Ultimate User Agreements and compliance withmedication management policies. 4. Facility Administrator Implementation: The FacilityAdministrator is tasked with the responsibility for the implementation andongoing oversight of this Plan of Correction. 5. Corrected on 10/15/2024. 6. Documentation: all appropriate documents havebeen uploaded	10/15/2024
1300 SS= C	Discrimination prohibited - NRS 449.101 Discrimination prohibited; development of antidiscrimination policy; posting of nondiscrimination statement and certain other information; construction of section. [Effective January 1, 2020.] 1. A medical facility, facility for the dependent or facility which is otherwise required by regulations adopted by the Board pursuant to NRS	1300	1.The facility has immediately post the Nevada Division ofPublic and Behavioral Health's (DPBH) contact information in all common publicareas accessible to residents, visitors, and staff. This includes the frontlobby, dining area, and other high-traffic spaces within the facility. Thecontact information will clearly indicate that	10/30/2024

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	449.0303 to be licensed and any employee or independent contractor of such a facility shall not discriminate in the admission of, or the provision of services to, a patient or resident based wholly or partially on the actual or perceived race, color, religion, national origin, ancestry, age, gender, physical or mental disability, sexual orientation, gender identity or expression or human immunodeficiency virus status of the patient or resident or any person with whom the patient or resident associates. 2. A medical facility, facility for the dependent or facility which is otherwise required by regulations adopted by the Board pursuant to NRS 449.0303 to be licensed shall: (a) Develop and carry out policies to prevent the specific types of prohibited discrimination described in the regulations adopted by the Board pursuant to NRS 449.0302 and meet any other requirements prescribed by regulations of the Board; and (b) Post prominently in the facility and include on any Internet website used to market the facility the following statement: [Name of facility] does not discriminate and does not permit discrimination, including, without limitation, bullying, abuse or harassment, on the basis of actual or perceived race, color, religion, national origin, ancestry, age, gender, physical or mental disability, sexual orientation, gender identity or expression or HIV status, or based on association with another person on account of that person's actual or perceived race, color, religion, national origin, ancestry, age, gender, physical or mental disability, sexual orientation, gender identity or expression or HIV status. 3. In addition to the statement prescribed by subsection 2, a facility for skilled nursing, facility for intermediate care or residential facility for groups shall post prominently in the facility and include on any Internet website used to market the facility: (a) Notice that a patient or resident who has experienced prohibited discrimination may file a complaint with the Division; and (b) The contact information for the Division. 4. The provisions of this section shall not be construed to: (a) Require a medical facility, facility for the dependent or facility which is otherwise required by regulations adopted		residents can file complaintsrelated to discrimination. 2.The facility will revise its admissions and orientationprocess to ensure that information on filing discrimination complaints isprovided to every resident upon admission. Additionally, a periodic walkthroughwill be implemented to confirm that required postings, including the DPBHcontact information, remain in place and visible. 3. Office Manager will conduct a weekly audit for thefirst month following the corrective action and then monthly to ensure the DPBHcontact information remains posted in all common areas. Results of the auditwill be documented and reviewed in monthly administrative meetings to addressany ongoing issues. 4. Facility Administrator Implementation: The FacilityAdministrator is tasked with the responsibility for the implementation andongoing oversight of this Plan of Correction. 5. Corrected on 10/30/2024. 6. Documentation: all appropriate documents have beenuploaded. 7. The facility will conduct a review of all required publicpostings to identify any other regulatory information that may not beprominently displayed. Any missing information will be added to ensurecomprehensive compliance across all areas.	

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	by the Board pursuant to NRS 449.0303 to be licensed or an employee or independent contractor thereof to take or refrain from taking any action in violation of reasonable medical standards; or (b) Prohibit a medical facility, facility for the dependent or facility which is otherwise required by regulations adopted by the Board pursuant to NRS 449.0303 to be licensed from adopting a policy that is applied uniformly and in a nondiscriminatory manner, including, without limitation, such a policy that bans or restricts sexual relations. Inspector Comments: Based on observation and interview, the facility failed to post prominently in the facility the State contact information to file a complaint for a resident who may have experienced prohibited discrimination. Findings include: On 09/26/2024 at 11:03 AM, the facility lacked posted documentation of the State contact information to file a complaint for any resident who may experience discrimination. On 09/26/2024 at 11:03 AM, the Admissions and Office Manager acknowledged the State's contact information had not been posted in any common public area of the facility to inform residents where to file a complaint of discrimination. Severity: 1 Scope: 3			
1700 SS= D	Annual Assessment of History of Each Resident - NRS 449.1845 Administrator of residential facility for groups to conduct annual assessment of history of each resident and cause provider of health care to conduct certain examinations and assessments; placement based on assessment. 1. The administrator of a residential facility for groups shall: (a) Annually cause a qualified provider of health care to conduct a physical examination of each resident of the facility; (b) Annually conduct an assessment of the history of each resident of the facility, which must include, without limitation, an assessment of the condition and daily activities of the resident during the immediately preceding year; and (c) Cause a qualified provider of health care to conduct an assessment of the condition and needs of a resident of the facility to	1700	1. Standard Physician’splacement determination and assessment have been completed for Residents #3 and#8 when the homebased provider came.They have been placed in each resident's clinical record and a copy provided tothe resident or their representative. 2. Addressed the facility’s annual procedures that includethe physician assigned to each resident to include the completion of annual placementdetermination and assessment with residents that have changes. Staff Training:Conduct training sessions for all staff to emphasize the importance of placementdetermination and physicians’ assessment, ensuring compliance with updated annualdocument procedures.	10/15/2024

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	determine whether the resident meets the criteria prescribed in paragraph (a) of subsection 2: (1) Upon admission of the resident to the facility; and (2) If a physical examination, assessment of the history of the resident or the observations of the administrator or staff of the facility, the family of the resident or another person who has a relationship with the resident indicate that: (I) The resident may meet those criteria; or (II) The condition of the resident has significantly changed. 2. If, as a result of an assessment conducted pursuant to paragraph (c) of subsection 1, the provider of health care determines that the resident: (a) Suffers from dementia to an extent that the resident may be a danger to himself or herself or others if the resident is not placed in a secure unit or a facility that assigns not less than one staff member for every six residents, any residential facility for groups in which the resident is placed must meet the requirements prescribed by the Board pursuant to subsection 2 of NRS 449.0302 for the licensing and operation of residential facilities for groups which provide care to persons with Alzheimer's disease or other severe dementia. (b) Does not suffer from dementia as described in paragraph (a), the resident may be placed in any residential facility for groups. 3. As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031. (Added to NRS by 2019, 2594) Inspector Comments: Based on record review and interview, the facility failed to obtain an initial and an annual Standard Physician Assessment and Placement Determination for 2 of 10 residents (Resident #3 and #8). Findings include: Resident #3 Resident #3 was admitted to the facility on 12/01/2019 with diagnoses including dementia due to another medical condition, without behavioral disturbance, benign hypertension with chronic kidney disease stage III, and diffuse cerebral atrophy. Resident #3's clinical record contained a Standard Placement Determination dated 01/16/2020. The clinical record lacked documented evidence of an annual Standard Placement Determination. On 09/26/2024 at 11:46 AM,		3. Regular Audits: The Facility Administrator, inconjunction with the management staff, will conduct monthly audits of residentfiles to verify the presence of physician’s placement determination andphysician’s assessment in compliance with annual placement determinationprocesses when diagnosis change. 4. Facility Administrator Implementation: The FacilityAdministrator is tasked with the responsibility for the implementation andongoing oversight of this Plan of Correction. 5. Corrected on 10/15/2024. 6. All appropriate documentation has been uploaded. 7. Facility-Wide File Review: Conduct a comprehensive reviewof all resident files to identify and correct any similar deficienciesregarding annual documentation. Included with the physician’s checklist whenthe homebased care visits or resident attends annual exam.	

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	the Admissions and Office Manager confirmed a Standard Physician Assessment and Placement Determination had not been completed annually for Resident #3. Resident #8 Resident #8 was admitted to the facility on 12/18/2020 with diagnoses including moderate late onset Alzheimer's dementia, peripheral vascular disease, and chronic pain syndrome, and bipolar disorder with depression. Resident #8's clinical record contained a Standard Placement Determination dated 12/18/2020. The clinical record lacked documented evidence of an annual Standard Placement Determination. On 09/26/2024 at 12:56 PM, the Admissions and Office Manager a Standard Physician Assessment and Placement Determination had not been completed annually for Resident #8. Severity: 2 Scope: 1			