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 _____	**03/03/2025**

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 complaint (CPT) investigation conducted at your facility on 03/03/2025. 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 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 seven Category II residents. The census at the time of the survey was ten. The sample size was five. Five resident files were reviewed. One CPT was investigated. CPT #NV00073536 was substantiated (see tag Y0174, Y0178, and Y0356). 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: EVA BELTEJAR Title: Owner Date: 03/21/2025

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.

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 _____	**03/03/2025**

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
0174 SS= E	Health& Sanitation-odors-hazards-insects-dirt - NAC 449.209 Health and sanitation. (NRS 449.0302) 4. To the extent practicable, the premises of the facility must be kept free from: (a) Offensive odors; (b) Hazards, including obstacles that impede the free movement of residents within and outside the facility; (c) Insects and rodents; and (d) Accumulations of dirt, garbage and other refuse. Inspector Comments: Based on observation and interview, the facility failed to ensure the facility was free from safety hazards. Findings include: On 03/03/2025 at approximately 11:05 AM, the Owner verbalized seven residents resided on the second floor and three residents resided on the first floor of the building. The residents residing on the first floor were able to go up and down the stairs without staff assistance. On 03/03/2025 at 11:15 AM, the carpet on the top step of the interior stairway between the first and second floors of the facility was loose. The carpet edge was pulled away slightly from the step and moved easily. On 03/03/2025 at 11:32 AM, the Owner confirmed the carpet on the top step of the interior stairway between the first and second floors of the facility was loose. The Owner explained staff had started to remove the carpet during the weekend prior so it could be replaced however the facility did not have all necessary supplies to complete the task. The carpet had been placed back on the step but was not tacked down to prevent it from moving. Severity : 2 Scope : 2	0174	1. The loose carpet on the stairs has been trimme and tacked down and a safety ledge installed to ensure it will not move. The bannister has been sanded and repainted. 2. A maintenance contractor has been hired by the facility and will inspect sites every month to ensure no safety hazards and fix things immediately. 3. Owner Eva Beltejar-Difuntorum and manager Vae Beltejar will ensure this has been completed. 4. Date corrected on 03.03.2025 6. Documentation provided. 7. A facility wide inspection was completed to identify any other environmental items that were in need of repair and corrected. This will happen evert month and reported to contracted maintenance for immediate repairs.	03/03/2025

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 _____	**03/03/2025**

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
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 railing around the second floor deck was free from peeling varnish. Findings include: On 03/03/2025 at 10:53 AM, the coating on the wooden railing around the outer edge of the second floor deck was peeling along the railing. On 03/03/2025 at 11:00 AM, Resident #4 verbalized the resident had lived in the facility for several years and liked to sit on the deck to read. On 03/03/2025 at 11:32 AM, the Owner confirmed the coating on the railing around the second floor deck was peeling and verbalized the railing was in need of refinishing. The Owner verbalized the varnish peeled every year due to the cold winter weather and the facility had been waiting for warmer weather to begin sanding and painting the railing. Severity : 2 Scope : 1	0178	1. The deck banister has been sanded, repainted and varnished.Faux wood and plastic deck rail coverings have been ordered to help mitigatethe need to repaint banister every year. Will be installed May 2025. 2. A maintenance contractor has been hired by the facilityand will inspect sites every month to ensure no safety hazards and fix thingsimmediately. 3. Owner EvaBeltejar-Difuntorum and manager Vae Beltejar will ensure this has beencompleted. 4. Date corrected on 03.03.2025 6. Documentation provided. 7. A facility wide inspection was completed to identifyany other environmental items that were in need of repair and corrected. Thiswill happen evert month and reported to contracted maintenance for immediaterepairs.	03/03/2025

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 _____	**03/03/2025**

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
0356 SS= E	Bathrooms and Toilet Facilities - NAC 449.222 Bathrooms and toilet facilities; toilet articles. (NRS 449.0302) 6. Bathroom doors that are equipped with locks must open with a single motion from the inside without the use of a key. If a key is required to open a lock from outside the bathroom, the key must be readily available at all times. Inspector Comments: Based on observation and interview, the facility failed to ensure a resident bathroom door was equipped with a single motion lock. Findings include: On 03/03/2025 at approximately 11:05 AM, the Owner verbalized seven residents resided on the second floor and three residents resided on the first floor of the building. On 03/03/2025 at 11:32 AM, the first floor resident bathroom was equipped with a sliding barn style door. A hook was secured to the frame of the doorway. To lock the door, the door was slid closed and the hook was placed into the handle of the door. The Owner demonstrated residents were able to unlock the door by removing the hook from the handle, then sliding the door open. The Owner confirmed the bathroom door, when locked, could not be opened with a single motion. Severity: 2 Scope: 2	0356	1. All locks in the facility including the downstairsbathroom have been replaced with a single motion lock. 2. A maintenance contractor has been hired by the facilityand will inspect sites every month to ensure no safety hazards and fix thingsimmediately. 3. Owner EvaBeltejar-Difuntorum and manager Vae Beltejar will ensure this has beencompleted. 4. Date corrected on 03.03.2025 6. Documentation provided. 7. A facility wide inspection was completed to identifyany other environmental items that were in need of repair and corrected. Thiswill happen evert month and reported to contracted maintenance for immediaterepairs.	03/19/2025