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
	5723	A. BUILDING _____ B. WING _____	09/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CESSABELLA RESIDENTIAL SUITE LLC #1	**8295 OPAL STATION DR, 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 the result of a State Licensure COVID-19 Infection Control and Prevention Plan follow up Survey conducted in your facility on 09/23/20. 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 is licensed for eight Residential Facility for Group beds for elderly and disabled persons, persons with mental illness, persons with chronic illness, and individuals with intellectual disabilities Category II residents. The census at the time of the survey was eight. The facility did not have an Infection Control and Prevention Plan documented and ready for implementation and the Owner was unable to provide a plan via email (See Tag Y 0593). The investigation of the facility's Infection Control and Prevention Plan included: - Observation of visitor entry and facility screening practices including observation of a visitor entering the facility without being screened or asked to don a facial covering; - Observation of a Caregiver wearing a mask with a hole over the portion designed to cover the mouth and providing care to residents; - Observation of signage at facility entrance documenting residents could have visits from one family member at a time; - A brief tour of the facility including common areas and bathrooms for resident use; - Review of logs for screening temperature and signs and symptoms of facility staff and residents; and - A verbal interview with two Caregivers and a phone interview with the Owner describing the facility's plan and procedures. The findings and conclusions of any investigation by the Health Division 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. The following deficiencies were identifiied.	0000		
0593 SS= F	Rights of Residents; Procedure for Filing - NAC 449.268 Rights of residents; procedure for filing grievance, complaint or	0593	Caregivers have been trained	05/12/2021

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: 05/12/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5723	A. BUILDING _____ B. WING _____	09/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CESSABELLA RESIDENTIAL SUITE LLC #1	8295 OPAL STATION DR, 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
	report of incident; investigation and response. (NRS 449.0302) 1. The administrator of a residential facility shall ensure that: (d) The facility is a safe and comfortable environment; Inspector Comments: Based on observation, interview, and record review, the facility failed to provide a safe environment for residents by not screening visitors for temperature and signs and symptoms of COVID-19 upon entering the facility, requiring visitors to wear a mask when in the facility, restricting visitors to essential personnel and end of life visitation by family, screening residents and staff for signs and symptoms of COVID-19 daily, having caregivers wear personal protective equipment (PPE) appropriately, having a cohort plan, having an inventory of PPE, having staff fit tested for N95 respirators, and having a documented infection control and prevention plan. Findings include: On 09/01/20, the Administrator-designee verbalized an Infection Control and Prevention Plan would be completed for the facility on 09/15/20. A follow-up survey conducted on 09/23/20 revealed the following components were lacking from the facility's plan and availability to implement: On 09/23/20 at 10:30 AM, a sign posted on the front door of the facility documented only one family member would be permitted to visit a resident at a time. On 09/23/20 at 10:38 AM, a Caregiver verbalized the facility was allowing family members to visit residents inside the facility. On 09/23/20 at 10:42 AM, a visitor arrived and was not screened by a Caregiver. The visitor was not wearing a facial covering and walked into the living room where three residents were seated watching television. A Caregiver confirmed the visitor had not been screened upon entry and the visitor was not wearing a facial covering. The Caregiver brought the visitor back to the front entrance and screened the visitor. The visitor was then allowed to walk back to the living room without a facial covering. On 09/23/20 at 10:42 AM, a Caregiver verbalized the facility did not screen residents or staff for signs and symptoms. On 09/23/20 at 10:48 AM, a Caregiver had		and oriented on the facility's"Infection Prevention and Control Plan." They have been educated by the administrator on the facility’s policy on only allowing essential personnel and end of life visitation for residents during theCOVID-19 pandemic. A sign reflecting this new policy has also been attached to the front door of the facility. For essential personnel and end of life visitors visiting the facility, the caregivers have been trained on how to properly screen for signs and symptoms, check the visitor’s temperature, log the data, ask the visitor to sanitize their hands, and ensure the visitor is wearing proper face coverings prior to entering the facility. Caregivers have also been educated on the importance of wearing proper face coverings while working at the facility and with residents during the COVID-19 pandemic. They have been provided with proper face coverings to use during their shift by the facility. Attached is a copy of the facility’s “Infection Prevention and Control Plan" for review by the state.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	5723	A. BUILDING _____ B. WING _____	09/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CESSABELLA RESIDENTIAL SUITE LLC #1	**8295 OPAL STATION DR, 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
	a dime sized hole in the center of the Caregiver's mask directly over the area intended to cover the mouth. The Caregiver confirmed the mask had a hole over the area meant to cover the mouth and the mask was ineffective because of the hole. On 09/23/20 at 10:50 AM, during a phone call with the Owner, the Owner verbalized the Owner would be able to email the facility's Infection Control and Prevention Plan, cohort plan, PPE inventory and fit testing documentation by 5:30 PM. The Owner was unable to provide the requested documentation. Severity: 2 Scope: 3			