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
	7195	A. BUILDING _____ B. WING _____	08/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT PAUL HOME CARE III	4910 KOENIG RD, 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 Survey conducted in your facility on 08/28/20. 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 ten Residential Facility for Group beds for elderly and disabled persons and/or mental illness, three Category I and seven Category II residents. The census at the time of the survey was ten. The facility did not have an Infection Control and Prevention Plan documented. Documented resources were provided to the facility for guidance in constructing a plan specific to their facility. The Owner verbalized their plan would be documented and ready for a follow-up review by 09/18/20. The facility plan is expected to include, at a minimum, the following components: -Visitor entry and facility screening practices; -An Emergency Staffing Plan if a staff member tests positive -A plan in the event a staff member or resident tests positive -Access to or inventory of Personal Protective Equipment (PPE) -Staff training on the proper use of PPE to include donning and doffing - Staff Fit Testing for N-95 masks -Respirator Program - Identification and response to residents with suspected or confirmed COVID-19 -New Admissions or Readmissions with an unknown COVID-19 status -Required notifications 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. No regulatory deficiencies were identified.	0000		

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: Title: Date: