

Division of Public and Behavioral Health

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>7317</b>                | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/23/2020</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CORINTHIAN PLACE, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br><b>2630 SUNRAY DR, RENO, NEVADA ,89503</b> |                                                                                                                          |                                                        |
| (X4)<br>ID<br>PREFIX<br>TAG<br><br><b>0000</b>                   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY<br>OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG<br><br><b>0000</b>                                                  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE                             |
|                                                                  | <p>Initial Comments</p> <p>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 07/23/20. 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 or disabled persons with eight Category II residents. The census at the time of the survey was 8. 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 08/10/20. 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.</p> |                                                                                         |                                                                                                                          |                                                        |

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 Name: Title: Date:  
REPRESENTATIVE'S SIGNATURE