

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 7317	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/11/2020
NAME OF PROVIDER OR SUPPLIER CORINTHIAN PLACE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2630 SUNRAY DR, RENO, NEVADA ,89503		
(X4) ID PREFIX TAG 0000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG 0000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as the result of a State Licensure COVID-19 follow-up Infection Control and Prevention Plan Survey conducted in your facility on 08/11/20. 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, eight Category II residents. The census at the time of the survey was eight. There were no positive or presumptive COVID-19 residents or staff at the time of the survey. Staff and residents were screened daily for temperature and signs and symptoms of COVID-19 and were documented by day on a monthly spreadsheet. The facility utilized the front entrance as the main access point. All staff members and essential visitors were required to complete a verbal questionnaire for COVID-19 signs and symptoms, have their temperature taken, were instructed to wear a surgical mask, spray disinfectant on the bottoms of their shoes, and to use an alcohol based hand sanitizer. All of these items were available on the table inside the foyer. Observed staff wearing masks and gloves with all resident care. All residents were observed to be socially distanced in the common area and the dining area. Interviews conducted with the two caregivers revealed the facility maintained an adequate supply of the following personal protective equipment: disposable gowns, gloves, surgical masks, faceshields, and N95 masks. Three facility staff members had completed N95 Fit testing and the documents were available for review. The facility provided continuing education on Infection Prevention and Control Training to staff members through review of the Centers for Disease Control and Prevention (CDC) guidelines during weekly huddles. A review of the facility's Infection Control and Prevention Plan revealed the facility had the following components documented and ready for			

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:

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	implementation: The review of the plan included the following: -A verbal interview with Administrator describing implementation of the plan -Visitor entry and facility screening practices -An Emergency Staffing Plan if a staff member tested positive -A plan if a resident tested 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 Tests 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.			