STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7317	A. BUILDING _____ B. WING _____	10/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORINTHIAN PLACE, LLC	**2630 SUNRAY DR, RENO, NEVADA ,89503**

(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 annual grading survey conducted at your facility on 10/17/22. This 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 and provides assisted living services. The census at the time of the survey was eight. Eight resident files were reviewed and four employee files were reviewed. The facility received a grade of A. 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 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 identified:	0000		
0620	Written Policy on Admissions - NAC 449.2702 Written policy on admissions; eligibility for residency. (NRS 449.0302) 4. Except as otherwise provided in NAC 449.275 and 449.2754, a residential facility shall not admit or allow to remain in the facility any person who: (a) Is bedfast; (b) Requires restraint; (c) Requires confinement in locked quarters; or (d) Requires skilled nursing or other medical supervision on a 24-hour basis. Inspector Comments: Based on observation and interview, the facility failed to discharge a resident receiving skilled nursing for wound care for 1 of 8 residents (Resident #6). Findings include: Resident #6 Resident #6 was admitted to the facility on 04/29/22, with diagnoses including cellulitis of left lower limb, diabetes type 2 and hypothyroidism. Resident #6's clinical record lacked documented evidence of an approved exemption request for wound care from the State of Nevada. On 10/17/22 at 11:03 AM, the Caregiver verbalized Resident #6 was receiving wound care from a home health agency nurse. Severity: 2 Scope: 1	0620	**1. How you will correct the specific finding (s) stated in the Statement of Deficiencies** Facility is in compliance. Resident 6 is alert and oriented. Resident 6 is able to bear weight and transfer to the wheelchair with minimum assist. Resident 6 goes out once a month using a wheelchair for her doctor's appointment assisted by her daughter. Facility took extra measure to bring the matter to the Nevada Department of Health and Human Services Division of Public and Behavioral Health. The waiver was	10/24/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7317	A. BUILDING _____ B. WING _____	10/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORINTHIAN PLACE, LLC	**2630 SUNRAY DR, RENO, NEVADA ,89503**

(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
			approved just two days after submitting all the requirement. Please see attached file for the Waiver (A). **2. What measures or systematic change (s) will be put into place to ensure the deficient practice does not recur** The Facility owner and the Administrator will ensure that before admission of any resident and/or anyone who need medical exemption shall obtain necessary supporting documents and will file it online at https://dpbh.nv.gov/Reg/HealthFacilities/HF_-_Non-Medical/Residential_Facilities_for_Groups_(Files)/Bedfast-Exemption/. Facility will ensure that any resident that wishes to stay in bed most of the time even though they are able to transfer will be required to obtain the waiver.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7317	A. BUILDING _____ B. WING _____	10/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORINTHIAN PLACE, LLC	**2630 SUNRAY DR, RENO, NEVADA ,89503**

(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
			3. How the corrective action (s) will be monitored to be ensure the deficient practice will not recur Facility is in compliance. Administrator will ensure that all future residents who wishes to reside at Corinthian Place shall be screened prior to admission and will apply for the waiver when the resident prefers to stay in bed even though they are able to transfer/ ambulate with minimal assist. Furthermore: caregivers shall be instructed to report any onset of pressure ulcer or any changes in the resident using a form that was generated to monitor such incident. Please see attached Monitoring Form (B). **4. The title of the person (position) responsible for ensuring the plan of correction is implemented** Facility owner and Administrator	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	7317	A. BUILDING _____ B. WING _____	10/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORINTHIAN PLACE, LLC	**2630 SUNRAY DR, RENO, NEVADA ,89503**

(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
			Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state/ federal law.	