DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**04/25/2024**

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

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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 04/26/2024. 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 six. Six resident files were reviewed and five employee files were reviewed. The facility received a grade of B. There were two complaints investigated. Complaint #NV00068798 with the following allegations could not be substantiated: Allegation #1: A resident was neglected by staff. Allegation #2: The call bell system was not answered timely. Complaint #NV00068840 with the following allegation could not be substantiated: Allegation #1: Care staff were not qualified. The investigation into the allegations included the following: Observation of the interactions between residents and staff, and appearance of residents. Interviews with three residents, the Administrator, and a caregiver. Review of six resident records. The review included hospice records. Document review of five employee training files including medication management, annual caregiver trainings, and background checks 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		
0178 SS= F	Health & Sanitation - Maintain Int/ext - NAC 449.209 Health and sanitation. (NRS 449.0302) 5. The administrator of a	0178	1. How you will correct the specific finding(s) stated in the Statement of	04/25/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: EUGENE GASATAYA Title: ADMINISTRATOR Date: 05/07/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	residential facility shall ensure that the premises are clean and that the interior, exterior and landscaping of the facility are well maintained. Inspector Comments: Based on observation and interview, the facility failed to ensure the exterior premises was maintained. Findings include: On 04/25/2024 at 9:38 AM, during a facility tour, on the side of the shed were the following items: -hospital bed frame -walker -air mattress -commode -foam cushions On 04/25/2024 at 9:44 AM, the Owner confirmed the debris lying on the side of the shed and verbalized was waiting for better weather to dispose of the debris. Severity: 2 Scope: 3		Deficiencies (MUST ADDRESS); **1.1 IMMEDIATE REMOVAL:** All hospital beds, walkers, and other equipment stored improperly in the shed and at the side of the shed will be promptly removed and/or relocated to designated storage areas within the group home. *(Please refer to Attachment I - Actual Photos of the Cited Areas)* 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur (MUST ADDRESS); **2.1 INVENTORY AND ORGANIZATION:** A thorough inventory of all equipment will be conducted, and items will be organized and stored appropriately in designated storage areas to prevent future issues. **2.2 STAFF EDUCATION:** Staff members will receive training on the proper storage of equipment and the importance of maintaining a clean and organized environment. Emphasis will be placed on compliance with state regulations and the role of each staff member in upholding health and sanitation standards. *(Please refer to Attachment II - Staff Training)*	

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			3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur (MUST ADDRESS); 3.1 REGULAR MONITORING: Routine inspections of the premises will be conducted to ensure compliance with health and sanitation regulations. Any deviations from the policy will be addressed promptly, and corrective actions will be taken as necessary. 3.2 DOCUMENTATION: All actions taken to address the citation and ensure compliance will be thoroughly documented, including inventory records, training sessions, and inspection reports. *Corinthian Place LLC is dedicated to maintaining a safe, clean, and healthy environment for all residents. By implementing this plan of correction, we are committed to upholding the highest standards of health and sanitation in accordance with state regulations.* 4) The title of the person (position) responsible for ensuring the plan of correction is implemented (DO NOT INCLUDE PERSONAL NAMES, JUST USE THE TITLE or POSITION) (MUST	

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			ADDRESS); Administrator and Facility Owner 5) The date the corrective action will be completed (MUST INCLUDE); Removal: April 25, 2024; Staff Education: May 5, 2024	
0878 SS= D	Medication/OTCS, Supplements, Change Order - NAC 449.2742 and R043-22 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 5. An over-the-counter medication or a dietary supplement may be given to a resident only if the resident's physician , physician assistant or advanced practice registered nurse has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician, physician assistant or advanced practice registered nurse. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician, physician assistant or advanced practice registered nurse. The administration of over-the-counter medications and dietary supplements must be included in the record required pursuant to paragraph (b) of subsection 1 of NAC 449.2744. 6. Except as otherwise provided in this subsection, a medication prescribed by a physician, physician assistant or advanced practice registered nurse must be administered as prescribed by the physician, physician assistant or advanced practice registered nurse. If a physician, physician assistant or advanced practice registered nurse orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order; (2) Indicate on the	0878	1. How you will correct the specific finding (s) stated in the Statement of Deficiencies (MUST ADDRESS); **1.1 IMMEDIATE CORRECTION:** Upon identification of the discrepancy between the prescribed dosage and the medication onsite for Resident #5, immediate action was taken. A corrected medication order was obtained from the physician specifying the dosage of 3 milligrams (mg) for Melatonin, aligning with the medication available onsite. *(Please refer to Attachment III - Physician's Order for Correct Dosage).* 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur (MUST ADDRESS); 2.1 **RESIDENT REVIEW:** A thorough review of all residents' medication orders has been conducted to ensure alignment with the medications available onsite. Any discrepancies have been promptly addressed by obtaining corrected orders from the respective physicians, as necessary.	04/25/2024

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	container of the medication that a change has occurred; and (3) Note the change in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; (b) Within 5 days after the change is ordered, a copy of the order or prescription signed by the physician, physician assistant or advanced practice registered nurse must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; and (c) If the label prepared by a pharmacist does not match the order or prescription written by a physician, physician assistant or advanced practice registered nurse, a physician, registered nurse or pharmacist must interpret that order or prescription and, within 5 days after the change is ordered, the interpretation must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744. Inspector Comments: Based on record review, observation and interview, the facility failed to ensure medications onsite were for the prescribed doseage for 1 of 6 sampled residents (Resident #5). Findings include: Resident #5 Resident #5 was admitted to the facility on 08/30/23, with diagnoses including cerebral vascular accident, aphasia, and dysphagia. On 04/25/2024 at 12:46 PM, during a review of the resident's medications the following medication was not being administered as prescribed; -Melatonin 3 milligram (mg) tablet, take one tablet by mouth every night at bedtime. Resident #5's April 2024 Medication Administration Record (MAR) and a physician's order dated 10/18/2023, documented Melatonin 5 mg tablet, take one tablet by mouth every night at bedtime. On 04/25/2024 at 12:49 PM, the Caregiver confirmed the Melatonin tablet onsite was for 3 mg, and the physician's order was for 5 mg. The Caregiver explained the Melatonin tablets onsite were not the prescribed dosage for Resident #5. Severity: 2 Scope: 1		2.2 **STAFF EDUCATION AND TRAINING:** All caregiving staff members have undergone re-education and training regarding the importance of adhering to prescribed medication dosages as per physician orders. This training emphasizes the significance of meticulous attention to detail in medication administration and the necessity of promptly addressing any deviations from prescribed dosages. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur (MUST ADDRESS); 3.1 **ROUTINE MEDICATION AUDITS:** To prevent recurrence of medication dosage discrepancies, routine medication audits will be implemented. These audits will involve cross-referencing medication orders with the medications available onsite, ensuring consistency and accuracy. Any discrepancies identified during these audits will be promptly addressed by obtaining corrected orders from physicians. 3.2 **DOCUMENTATION:** All corrective actions taken in response to medication dosage discrepancies will be thoroughly documented in residents' records. This documentation will include details of the discrepancy, actions taken to rectify the issue, and any preventive measures implemented to ensure compliance with medication administration regulations.	

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			3.3 **ONGOING MONITORING:** Continuous monitoring of medication administration practices will be conducted to assess compliance with regulatory requirements and adherence to prescribed medication dosages. Any deviations or issues identified during this monitoring process will be promptly addressed through appropriate corrective actions. This plan of correction demonstrates Corinthian Place LLC's commitment to maintaining the highest standards of medication administration and resident care. By implementing these corrective measures and preventive strategies, we aim to prevent recurrence of medication dosage discrepancies and uphold the safety and well-being of our residents. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented (DO NOT INCLUDE PERSONAL NAMES, JUST USE THE TITLE or POSITION) (MUST ADDRESS); Administrator and Facility Owner 5) The date the corrective action will be completed (MUST INCLUDE); April 25, 2024	
1010 SS= D	Care for Persons with Mental Illnesses - NAC 449.2764 Residential facility which offers or provides care for persons with	1010	1. How you will correct the specific finding (s) stated in the Statement of Deficiencies	04/30/2024

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	mental illnesses: Application for endorsement; training for employees. (NRS 449.0302) 1. A residential facility which offers or provides care and protective supervision for a resident with mental illness must obtain an endorsement on its license authorizing it to operate as a residential facility for persons with mental illnesses. The Division may deny an application for an endorsement or suspend or revoke an existing endorsement based upon the grounds set forth in NAC 449.191 or 449.1915. Inspector Comments: Based on clinical record review and interview, the facility failed to obtain an endorsement for Mental Illness (MI) and admitted and retained a resident with a MI diagnosis for 1 of 6 sampled residents (Resident #2). Findings include: Resident #2 Resident #2 was admitted on 10/20/2023, with diagnoses including bipolar disorder, unspecified dementia , and mood disorder. A History and Physical dated 09/29/2023, documented Resident #2 had a diagnosis of bipolar disorder. The facility lacked an MI endorsement to admit and retain residents with MI. On 04/25/2024 at 11:13 AM, the Owner confirmed the facility was not endorsed for MI and Resident #2 had diagnosis of bipolar disorder. Severity: 2 Scope: 1		(MUST ADDRESS); **1.1 IMMEDIATE CORRECTION:** Upon identification of the deficiency in obtaining an endorsement for Mental Illness (MI), immediate action was taken to rectify the situation. The application process for obtaining the MI endorsement was initiated on April 30, 2024. All necessary steps will be taken to ensure compliance with licensing requirements. *(Please refer to Attachment VII - Application for Endorsement).* **1.2 TRAINING FOR EMPLOYEES:** To enhance the facility's capacity to care for residents with mental illnesses, comprehensive training programs have been implemented for all employees through Care Academy. The following course description are being completed: What are Mental Illnesses, Common Mental Illnesses in Older Adults, Diagnosis and Treatment of Mental Illness in Older Adults, and Supporting Older Adult with Mental Illness. *(Please refer to Attachment VIII - MI Training).* These training programs focus on topics related to mental illness, including understanding the signs and symptoms, effective communication strategies, de-escalation techniques, and promoting a supportive and therapeutic environment. **1.3 CONTINGENCY PLAN:** In the event that the endorsement for Mental Illness is not approved by the State, Corinthian Place LLC will adhere to applicable regulations	

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			and protocols. This includes providing a 30-day notice to Resident #2 to vacate the group home, as required by state regulations. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur (MUST ADDRESS); **2.1 DOCUMENTATION AND SUBMISSION OF APPLICATION:** Upon completion of the required training programs, documentation of employee training will be compiled and organized. The application for the MI endorsement, along with the documentation of employee training, will be uploaded to nvdpbh.aithent.com as per state regulations for processing. **2.2 STAFF EDUCATION AND OVERSIGHT:** All staff members will receive ongoing education and training to ensure competency in providing care for residents with mental illnesses. Supervisory oversight will be provided to ensure consistent implementation of best practices and adherence to regulatory requirements. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur (MUST ADDRESS); **3.1 ONGOING COMPLIANCE MONITORING:** Corinthian Place LLC is	

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			committed to maintaining compliance with regulatory requirements related to caring for persons with mental illnesses. Regular monitoring and review processes will be implemented to ensure ongoing adherence to licensing standards and the provision of quality care to residents. This plan of correction demonstrates Corinthian Place LLC's commitment to addressing deficiencies in obtaining the endorsement for Mental Illness and ensuring compliance with regulatory requirements for the benefit of our residents. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented (DO NOT INCLUDE PERSONAL NAMES, JUST USE THE TITLE or POSITION) (MUST ADDRESS); Administrator and Facility Owner 5) The date the corrective action will be completed (MUST INCLUDE); April 30, 2024	
1700 SS= E	Annual Assessment of History of Each Resident - NRS 449.1845 Administrator of residential facility for groups to conduct annual assessment of history of each resident and cause provider of health care	1700	1. How you will correct the specific finding(s) stated in the Statement of Deficiencies (MUST ADDRESS);	04/25/2024

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	to conduct certain examinations and assessments; placement based on assessment. 1. The administrator of a residential facility for groups shall: (a) Annually cause a qualified provider of health care to conduct a physical examination of each resident of the facility; (b) Annually conduct an assessment of the history of each resident of the facility, which must include, without limitation, an assessment of the condition and daily activities of the resident during the immediately preceding year; and (c) Cause a qualified provider of health care to conduct an assessment of the condition and needs of a resident of the facility to determine whether the resident meets the criteria prescribed in paragraph (a) of subsection 2: (1) Upon admission of the resident to the facility; and (2) If a physical examination, assessment of the history of the resident or the observations of the administrator or staff of the facility, the family of the resident or another person who has a relationship with the resident indicate that: (I) The resident may meet those criteria; or (II) The condition of the resident has significantly changed. 2. If, as a result of an assessment conducted pursuant to paragraph (c) of subsection 1, the provider of health care determines that the resident: (a) Suffers from dementia to an extent that the resident may be a danger to himself or herself or others if the resident is not placed in a secure unit or a facility that assigns not less than one staff member for every six residents, any residential facility for groups in which the resident is placed must meet the requirements prescribed by the Board pursuant to subsection 2 of NRS 449.0302 for the licensing and operation of residential facilities for groups which provide care to persons with Alzheimer's disease or other severe dementia. (b) Does not suffer from dementia as described in paragraph (a), the resident may be placed in any residential facility for groups. 3. As used in this section, "provider of health care" has the meaning		1.1 **IMMEDIATE CORRECTION:** Upon identification of the deficiency in completing annual Physician Placement Determinations for residents with a diagnosis of dementia, immediate action was taken. Requests were made to the primary physicians of all residents, including Residents #4 and #6, for updated Physician Placement Determinations to ensure their fitness for residence at Corinthian Place LLC. These requests were made on April 25, 2024. *(Please refer to Attachment V - Placement Determination)* 1.2 **DOCUMENTATION OF PHYSICIAN PLACEMENT DETERMINATIONS:** Upon receipt of updated Physician Placement Determinations, documentation will be promptly added to the clinical records of Residents #4 and #6, as well as all other residents, as part of their comprehensive medical history. These documents will be maintained in accordance with regulatory requirements and will be readily accessible for review as needed. 2) What measures or systematic	

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	ascribed to it in NRS 629.031. (Added to NRS by 2019, 2594) Inspector Comments: Based on interview and clinical record review, the facility failed to ensure physician placement determinations were completed annually by a provider for residents with a diagnosis of dementia for 2 of 6 residents (Resident #4 and #6). Findings include: Resident #4 Resident #4 was admitted to the facility on 02/27/2020, with a diagnosis of dementia. Resident #4's medical record included an initial Physician Placement Determination dated 02/02/2020. Resident #4's clinical record lacked documented evidence a Physician Placement Determination was completed in 2021, 2022, and 2023. Resident #6 Resident #6 was admitted to the facility on 10/14/2020, with a diagnosis of dementia. Resident #6's medical record included an initial Physician Placement Determination dated 10/14/2020. Resident #6's clinical record lacked documented evidence a Physician Placement Determination was completed in 2021, 2022, and 2023. On 04/25/2024 at 11:13 AM, the Owner verbalized Resident #4 and Resident #6 had a diagnosis of dementia. The Owner confirmed Physician Placement Determinations had not been completed in 2021, 2022, and 2023 for Residents #4 and #6. The Owner verbalized understanding of the requirement for Physician Placement Determinations to be completed annually for residents with a diagnosis of dementia. Severity: 2 Scope: 2		change(s) will be put into place to ensure the deficient practice does not recur (MUST ADDRESS); 5. **STAFF EDUCATION AND OVERSIGHT:** All staff members will receive education regarding the importance of completing annual Physician Placement Determinations for residents with a diagnosis of dementia. Regular oversight will be provided to ensure understanding and adherence to these protocols. **3. ANNUAL MONITORING:** To prevent recurrence of the deficiency in completing annual Physician Placement Determinations, Corinthian Place LLC will implement a comprehensive annual monitoring process. This process will include a systematic review of each resident's medical records to ensure that Physician Placement Determinations are completed annually by their respective primary physicians. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur (MUST ADDRESS);	

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			4. **MONITORING TRIGGER:** In addition to the annual monitoring process, Corinthian Place LLC recognizes the importance of conducting Physician Placement Determinations whenever there are significant changes in a resident's care needs or medical condition. As such, requests for updated Physician Placement Determinations will be made promptly in response to any changes observed by staff, family members, or other caregivers. *(Please refer to Attachment VI - Placement Determination updated Form).* This plan of correction demonstrates Corinthian Place LLC's commitment to addressing deficiencies in the completion of annual Physician Placement Determinations and ensuring ongoing compliance with regulatory requirements for the benefit of our residents. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented (DO NOT INCLUDE PERSONAL NAMES, JUST USE THE TITLE or POSITION) (MUST ADDRESS);	

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(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
			Administrator and Facility Owner 5) The date the corrective action will be completed (MUST INCLUDE); April 25, 2024	
1830 SS= F	Infection Control Required Training - Infection Control Required Training LCB File No. R048-22 Sec. 5 4. The persons designated pursuant to subsection 3 as responsible for infection control shall complete not less than 15 hours of training concerning the control and prevention of infections provided by the Association for Professionals in Infection Control and Epidemiology, Inc., the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the World Health Organization or the Society for Healthcare Epidemiology of America, or a successor in interest to any of those organizations, not later than 3 months after being designated and annually thereafter. 5. Training completed pursuant to subsection 4 may be in any format, including, without limitation, an online course provided for compensation or free of charge. A certificate of completion for the training must be maintained in the personnel file of each person designated pursuant to subsection 3 for 3 years immediately following the completion of the training. Inspector Comments: Based on personnel file review, document review, and interview, the primary and secondary infection control person lacked the required infection control	1830	1. How you will correct the specific finding (s) stated in the Statement of Deficiencies (MUST ADDRESS); 1.1 **IMMEDIATE CORRECTION:** Upon identification of the deficiency in infection control training for the primary and secondary infection control personnel, immediate action was taken to ensure compliance. Both the primary and secondary infection preventionists have completed the required 15 hours of training concerning the control and prevention of infectious diseases through CDC's Train.org platform. The training was successfully completed on May 1, 2024, for the primary infection preventionist and on April 30, 2024, for the secondary infection preventionist. *(Please refer to Attachment IV - Certificate of Training)* 1.2 **DOCUMENTATION:** Certificates of completion for the infection control training have been obtained and will be maintained in the personnel files of the Owner and Caregiver, designated as the primary and secondary infection control persons,	05/02/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	04/25/2024

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	training potentially affecting 6 of 6 residents. Findings include: On 04/25/2024 at 11:45 AM, the personnel files for the Owner and Caregiver, the primary infection person and the designee, respectively, lacked documented evidence of 15 hours of training concerning the control and prevention of infectious diseases from the approved nationally recognized organizations. The Caregiver provided evidence of completion of three hours of training on 11/06/2023, through the Centers for Disease Control and Prevention (CDC). The Owner and the Caregiver confirmed the required infection control and prevention training had not been completed. Severity: 2 Scope: 3		respectively. These certificates will be retained for a period of three years immediately following the completion of each training session, as required by regulation. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur (MUST ADDRESS); 2.1 **RENEWAL OF TRAINING:** Corinthian Place LLC recognizes the importance of ongoing education and training in infection control and prevention. To ensure continuous compliance with regulatory requirements and best practices, the infection control training will be renewed annually for both the primary and secondary infection preventionists. 2.2 **STAFF EDUCATION AND OVERSIGHT:** All staff members will receive education and training regarding the importance of infection control measures and the roles of designated infection preventionists. Regular oversight will be provided to ensure understanding and adherence to these protocols. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur (MUST ADDRESS); 3.1. **ANNUAL TRAINING SCHEDULE:** An annual training schedule will be established to facilitate timely completion of infection	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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		A. BUILDING _____ B. WING _____	**04/25/2024**

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			control training for designated personnel. This schedule will ensure that the required 15 hours of training are completed within the mandated timeframe and that certificates of completion are maintained up to date in personnel files. This plan of correction demonstrates Corinthian Place LLC's commitment to addressing deficiencies in infection control training and ensuring ongoing compliance with regulatory requirements. 4) The title of the person (position) responsible for ensuring the plan of correction is implemented (DO NOT INCLUDE PERSONAL NAMES, JUST USE THE TITLE or POSITION) (MUST ADDRESS); Administrator and Facility Owner 5) The date the corrective action will be completed (MUST INCLUDE); April 30, 2024 and May 1, 2024	