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 _____	**04/27/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STARLIGHT GROUP HOME	**2301 EAST 9TH ST., RENO, NEVADA ,89512**

(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 complaint investigation conducted at your facility on 04/27/21. This complaint investigation was conducted in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility was licensed for nine Residential Facility for Group beds for elderly and disabled persons, and/or persons with chronic illness, and/or persons with mental illness, and/or persons with Alzheimer's disease, Category II residents. The census at the time of the survey was six. The sample size was six residents. There was one complaint investigated. Complaint #NV00063567 was substantiated. The allegation a resident eloped from the facility was substantiated. (See Tag Y 0515). 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 investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:	0000		
0515 SS= D	Supervision and Treatment of Residents - NAC 449.259 Supervision and treatment of residents generally. (NRS 449.0302) 1. A residential facility shall: (a) Provide each resident with protective supervision as necessary; (b) Inform all caregivers of the required supervision; Inspector Comments: Mazy, Alicia Based on clinical record review and interview, the facility failed to ensure proper supervision of a resident resulting in a resident eloping from the facility for 1 of 6 sampled residents (Resident #1). Findings include: Resident #1 Resident #1 was admitted to the facility on 06/12/20, with diagnoses including psychosis, dementia, and anemia. On	0515	1-2. After the incident on 04/27/2021 re: elopement of resident no. 1. On 04/28/2021 the administrator immediately called a meeting to the caregivers of Starlight Grouphome. He immediately ordered to remove the three (3) trash bins near the fence and ordered them to be placed away from the fence so that residents cannot use the bins for elopement. Also, Administrator emphasized to the caregivers that If ever any of the residents will go to the backyard of the facility. They either be with them or keep an eye on them on a regular basis.	05/10/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | Name: ERNESTO BELTEJAR JR. | Title: ADMINISTRATOR | Date: 05/10/2021

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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	04/27/21 at 10:26 AM, Caregiver #1 explained on 03/27/21, Resident #1 went to the backyard to smoke a cigarette. There were three trash bins located next to a gate with a lock on the gate. Resident #1 put their foot on a metal bar, located on the trash bins, and was able to climb on top of the trash bins. Once on top of the trash bins, the resident climbed over the fence and started walking. After 10 minutes, the Caregivers went to the backyard to check on Resident #1 and discovered the resident was missing. The Caregiver who discovered Resident #1 was missing, called the Administrator to inform and searched the premises for the resident. The Caregivers could not find Resident #1 in the facility or the areas surrounding the facility. The Caregiver called the police department to inform a resident was missing. The police department was able to locate the resident at a friend's home and brought the resident back to the facility. Caregiver #1 confirmed Resident #1 was left unsupervised in the backyard resulting in the resident eloping from the facility. Caregiver #1 further explained Resident #1 had a history of eloping and needed more supervision. An Incident/Accident Report dated 03/27/21, documented around 4:15 PM on 03/27/21, a Caregiver was searching for Resident #1 after the resident had gone out to smoke a cigarette at 3:45 PM. The Caregiver found trash bins up against the side gate and assumed the resident had gotten out of the backyard by using the trash bins. At 5:00 PM on 03/27/21, the police department was called to report Resident #1was missing. Complaint #NV00063567 Severity: 2 Scope: 1		3-4. Administrator will monitor the facility on a weekly basis in such a way that the backyard are safe and there will be no items that are near the fence that can be used for elopement. He will also monitor that caregivers will be at the backyard or in close monitoring when there are residents outside (backyard) of the facility. 5. Meetings with the administrator has been done on 4/28/2021 and every week after administrator monitors the facility (backyard) and the caregivers.	