Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9326	A. BUILDING _____ B. WING _____	10/10/2022

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 an annual State Licensure Survey conducted at your facility on 10/10/22. This State Licensure Survey 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 eight. Eight resident files 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 investigations, 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		

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0933 SS= D	Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he or she permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including, without limitation: (d) A statement from the resident ' s physician concerning the mental and physical condition of the resident that includes: (1) A description of any medical conditions which require the performance of medical services; (2) The method in which those services must be performed; and (3) A statement of whether the resident is capable of performing the required medical services. Inspector Comments: Based on record review and interview, the facility failed to ensure a Physician Placement Determination Statement was accurately completed upon admission for 1 of 8 sampled residents (Resident #6). Findings include: Resident #6 Resident #6 was admitted to the facility on 05/01/22, with diagnoses including vascular dementia, hypertension, and chronic pain. Resident #6's clinical record contained a Physician Placement Determination Statement signed by the physician on 01/07/22, to determine the appropriate facility type and care for the resident; however, the document did not contain the resident's name. On 10/10/22 at 11:39 AM, the Manager confirmed Resident #6 had a Physician Placement Determination Statement signed by the physician on 01/07/22 and lacked the resident's name. The Manager verbalized when documents were received in the facility and lacked the resident's name the Administrator or the Manager was responsible for ensuring the information was filled in. Severity: 2 Scope: 1	0933	1. Manager corrected Resident no. 6 "Physician Placement Determination" by placing the residents name on the documents. 2. Administrator held a meeting with the Manager and caregivers that all documents received by the facility pertaining to a particular residents must be reviewed accurately - as to name, date, reason, healthcare provider signature etc. In this manner, documents can filed accurately and can be a reliable source as time needs it. 3. Administrator asked the manager to review all resident's file and make sure that they are updated, fully labeled and in compliance with the requirements. 4. Manager started reviewing the files on 10/12/2022 and he will do it on a monthly basis. Administrator will monitor this every month also.	11/16/2022

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0999 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 Residential facility which provides care to persons with Alzheimer ' s disease: Standards for safety; personnel required; training for employees. (NRS 449.0302) 1. The administrator of a residential facility which provides care to persons with Alzheimer ' s disease shall ensure that: (g) All toxic substances are not accessible to the residents of the facility. Inspector Comments: Based on observation and interview, the facility failed to ensure toxic items were secured in an Alzheimer's endorsed facility. Findings include: During a tour of the facility, a tube of face cream was found in the medicine cabinet in a common bathroom. On 10/10/22 at 9:57 AM, the Caregiver and Manager confirmed the tube of face cream should be secured from residents for resident safety. Severity: 2 Scope: 3	0999	1.Immediately, when the inspector pointed to us about a tube of face cream on Bathroom 1 and pointed to the facility that it can be toxic to the residents, Caregiver immediately removed such items and placed it in a secured place. see attachment no 1-2 2. To avoid same incident; the administrator held a meeting on 10/11/2022 and educate all caregivers: Caregiver 3 and Caregiver 4 that the facility is an " Alzheimer/Dementia Facility" and all non-edible substances, sharps, etc. should be locked in a secured cabinet and labeled; it should not be accessible to the residents and only the caregivers have access to the secured cabinets. The administrator will include this in the facility monitoring Checklist which the Lead Caregiver has to monitor on a daily basis. To make sure that all rooms, bathrooms, living rooms, etc. are free of harmful and toxic substances for the safety of the residents. 3-5. The Lead Caregiver started monitoring it on 10/11/2022 and she will be doing it on a daily basis. Administrator monitors this on a weekly basis.	11/16/2022

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1540 SS= B	Cultural Competency Training Inspector Comments: Based on personnel record review and interview, the facility failed to ensure cultural competency training was completed timely for 2 of 4 employees (Employees #3 and #4). Findings include: Employee #3 Employee #3 was hired as a Caregiver with a start date of 01/21/20. The personnel record for Employee #3 had a cultural competency training certificate dated 09/29/22. Employee #4 Employee #4 was hired as a Caregiver with a start date of 11/04/20. The personnel record for Employee #4 had a cultural competency training certificate dated 09/29/22. On 10/10/22 at 10:17 AM, the Manager confirmed the cultural competency training for Employee #3 and #4 was completed late. Severity: 1 Scope: 2	1540	1. Administrator admitted that Caregivers 3 and 4 "Cultural Competency Training" were late. 2. The Administrator will review all the checklist requirements in hiring a staff of the facility including all its necessary trainings, monitors the necessary continuing educations regularly in order for the staff not to be late and to be always in compliance as caregivers of the facility. 3. November 11, 2022, Administrator reviewed all employee files and makes sure that all necessary requirements were met. He will do the reviews every end of the month of each month regularly.	11/16/2022