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 _____	08/14/2024

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 State Licensure annual grading survey conducted at your facility on 08/14/2024. This survey was conducted by the Division of Public and Behavioral Health 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 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 C. NAC 449.27706 Resurvey: Application and fee; failure to comply. 2. If the Bureau issues a placard to a residential facility that includes a grade of "C" or "D," the administrator must submit an application to the Bureau for a resurvey of the facility not later than 30 days after the facility receives the placard. The fee for an application for a resurvey is $600 and must accompany the application. 3. The Bureau may revoke the license of a residential facility that is required to submit an application for a resurvey pursuant to subsection 2 if the facility fails to submit the application in accordance with the provisions of that subsection. 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		

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: ERNESTO BELTEJAR JR.	Title: Administrator	Date: 09/06/2024

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 _____	08/14/2024

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
0178 SS= E	Health & Sanitation - Maintain Int/ext - NAC 449.209 Health and sanitation. (NRS 449.0302) 5. The administrator of a 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 an area for resident use did not contain a broken table and the backyard was not used to store excess medical equipment. Findings include: On 08/14/2024 at 8:52 AM, a table against the corner of the house, next to the smoking area, on the attached deck had a broken and bent leg and the veneer tabletop was cracked and peeling away from the surface. The Caregiver1 confirmed the table was broken and the tabletop was peeling and cracked and verbalized the table needed to be thrown away. On 08/14/2024 at 8:53 AM, a wheelchair was lying, upside down, in the back yard, in front of a storage shed. The wheelchair had a large rock placed on the bottom of the seat. On 08/14/2024 at 12:40 PM Caregiver2 verbalized the chair was left in the backyard because the facility had run out of storage space in the shed. Severity: 2 Scope: 2	0178	1. On August 16, 2024 The Administrator had inspected the facility's environment including the whole exterior (front yard and back yard). He ordered to do a thorough cleaning and discard all items that are clutters and furnitures that are considered unsafe to use. These includes the the broken table and the wheelchair. (see attachments 1, 2 &3). 2. August 17, 2024, The Administrator created a Facility Monitoring Checklist that monitors all the structures and environment of the facility - both inside and outside. He instructed Caregiver 1 and 2 to follow the checklist and do on a daily basis. see attachment no. 4 3. Every two weeks (starting August 31, 2024) Administrator will inspect the facility to make sure that the facility is clean, uncluttered, and environment is safe and free from hazard. 4. In the absence of the Administrator Caregiver 4 will do the monitoring.	09/05/2024

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 _____	08/14/2024

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
0430	Requirements and Precautions - NAC 449.229 Requirements and precautions regarding safety from fire. (NRS 449.0302) 1. The administrator of a residential facility shall ensure that the facility complies with the regulations adopted by the State Fire Marshal pursuant to chapter 477 of NRS and all local ordinances relating to safety from fire. The facility must be approved for residency by the State Fire Marshal. 2. The Bureau shall notify the State Fire Marshal or the appropriate local government, as applicable, if, during an inspection of a residential facility, the Bureau knows of or suspects the presence of a violation of a regulation of the State Fire Marshal or a local ordinance relating to safety from fire. Inspector Comments: Based on observation, interview and document review, the facility failed to ensure the fire extinguishers were inspected at least once a year. Findings include: On 08/14/2024 at 8:46 AM, during the facility tour, the fire extinguisher at the end of the hallway off the common living area and the fire extinguisher next to the kitchen had inspection tags dated 06/28/2023. On 08/14/2024 at 12:40 PM, a Caregiver confirmed the findings.	0430	1. August 16, 2024 Administrator ordered Caregiver 2 to call the Fire Extinguishers Co. to recalibrate the (2) Two Fire Extinguishers of the facility. The Company came on August 27, 2024 calibrated and tagged the fire extinguishers. see attachment 1 & 2. 2. Administrator had created a Facility Monitoring Checklist on August 17, 2024 and included Fire Extinguishers to be monitored by the the caregivers on a daily basis and Administrator every 2 weeks started on August 31, 2024 see attachment no. 3. 3. In the absence of the Administrator Caregiver 4 will do the bi-weekly monitoring.	09/05/2024
0515 SS= F	Supervision and Treatment of Residents - NAC 449.259 & R043-22 Supervision and treatment of residents generally. (NRS 449.0302) 1. A residential facility shall ensure that the staff of the facility collaborate with each resident of the facility, the family of the resident and other persons who provide care for the resident, including, without limitation, a qualified provider of health care, as interpreted by section 8 of this regulation, to: (a) Develop a person-centered service plan for the resident; and (b) Review the person-centered service plan at least once each year.; Inspector Comments: Based on interview and record review, the facility failed to develop a person-centered service plan for 8 of 8 residents (Resident #1, #2, #3, #4, #5, #6, #7, and #8). Findings include: Resident #1 Resident #1 was admitted to the facility on 10/23/2023, with diagnoses	0515	1. August 16, 2024 Administrator inspects all the files of the residents and on August 20, 2024 completed all Resident's Person Centered Service Plan. see attachment no. 1, 2, 3, 4, 5, 6, 7 & 8. 2. Same day August 20, 2024 Administrator retrained all caregivers as to Record Keeping: these includes making sure that all files are complete and in accordance with BHCQC guidelines see attachment no. 9 3. August 31, 2024, Administrator had inspected the facility files these includes the Resident files and made sure that these are complete and in compliance. He will do these every end of the month. 4. In his absence Caregiver 4 will do the monitoring.	09/05/2024

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 _____	08/14/2024

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
	including cognitive decline and chronic obstructive pulmonary disease. Resident #1's record lacked a person-centered service plan. Resident #2 Resident #2 was admitted to the facility on 02/11/2024, with diagnoses including Parkinson's disease and muscle weakness. Resident #2's record lacked a person-centered service plan. Resident #3 Resident #3 was admitted to the facility on 07/01/2024, with diagnoses including seizures and nerve pain. Resident #3's record lacked a person-centered service plan. Resident #4 Resident #4 was admitted to the facility on 10/12/2023, with diagnoses including enlarged prostate and occluded urinary catheter. Resident #4's record lacked a person-centered service plan. Resident #5 Resident #5 was admitted to the facility on 09/20/2023, with diagnoses including nausea, dehydration, and weakness. Resident #5's record lacked a person-centered service plan. Resident #6 Resident #6 was admitted to the facility on 05/16/2024, with a diagnosis of dementia. Resident #6's record lacked a person-centered service plan. Resident #7 Resident #7 was admitted to the facility on 09/28/2023, with diagnoses including seizure, muscle weakness, and falls. Resident #7's record lacked a person-centered service plan. Resident #8 Resident #8 was admitted to the facility on 04/04/2024, with diagnoses including chronic kidney disease stage five and dialysis. Resident #8's record lacked a person-centered service plan. On 08/14/2024 at 12:40 PM, the Caregiver confirmed person-centered service plans were not developed for Resident #1, #2, #3, #4, #5, #6, #7, and #8. Severity: 2 Scope: 3			
0620 SS= D	Written Policy on Admissions - NAC 449.2702 and R043-22 Written policy on admissions; eligibility for residency. (NRS 449.0302) 4. Except as otherwise provided in NAC 449.275, 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.	0620	1. August 16, 2024 Administrator inspects all the files of the Residents. He included in Resident's 2 file the Bedfast Waiver approved by BHCQC on 08/21/2024 see attachment no. 1. 2. As the filing of the waiver was late, On August 20, 2024; Administrator retrained all caregivers as to Record Keeping: these includes managing Resident and Employee files and other forms of the facility see attachment no. 2	09/05/2024

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 _____	08/14/2024

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
	Inspector Comments: Based on observation, interview, record review, and document review, the facility failed to ensure a bedfast resident receiving skilled nursing services was not allowed to admit or remain in the facility for 1 of 9 residents (Resident #2). Findings include: Resident #2 Resident #2 was admitted to the facility on 02/11/2024, with diagnoses including Parkinson's disease and muscle weakness. On 08/14/2024 at 8:43 AM, Resident #2 was lying in bed in the resident's bedroom. The resident verbalized the resident was unable to get out of bed by themselves. A Physician's Medical Evaluation for Assisted Living, dated 02/10/2024, documented Resident #2 had a Percutaneous Endoscopic Gastrostomy (PEG) tube (a tube passed into the stomach through the abdominal wall). The resident was bed bound and required tube feeding. The resident needed total help with ambulating, bathing, dressing, grooming, and transferring. On 08/14/2024 at 10:20 AM, Caregiver1 verbalized the caregiver would crush the resident's medications, mix the medications with the resident's prescribed tube feeding formula and put the medications and formula through the resident's PEG tube with some water. Caregiver2 provided undated documentation of a bedfast waiver application for Resident #2. Caregiver2 verbalized the bedfast waiver had been submitted on 08/01/2024. On 08/14/2024 at 10:25 AM, Resident #2 explained the caregivers in the facility administered the medications and the tube feeding through the resident's PEG tube. The resident confirmed the resident did not assist the caregivers with the administration of the medications or administer the medications themselves. The August 2024 Medication Administration Record for Resident #2 documented the following medications were initialed as administered via the resident's PEG tube by caregivers in the facility: - Carbidopa-Levodopa 25-250 milligrams (mg), take one tablet via PEG tube twice a day for Parkinson's disease. - Trazodone Hydrochloride 50 mg, take one tablet by mouth daily at bedtime for difficulty sleeping. - Osmolite 8-ounce nutritional		3. On August 31, 2024, Administrator had inspected the facility files including the Resident, Employee , MAR and other forms of the facility. He will do this every end of the month. 4. In his absence, Caregiver 4 will do the monitoring.	

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 _____	08/14/2024

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
	drink, three times daily. On 08/14/2024 at 10:53 AM, a representative for the hospice agency providing services to the resident verbalized the hospice nurse visited the resident one time a week and the hospice was not providing daily visits for medication administration. On 08/14/2024 at 11:10 AM, Caregiver2 verbalized Caregiver2 did not realize the facility staff were not able to administer medications via a PEG tube and confirmed the facility staff had been administering the resident's medications. Caregiver2 confirmed the resident was bedbound and had a PEG tube upon admission to the facility, but the facility had not applied for a waiver until 08/01/2024. Severity: 2 Scope: 1			
0680 SS= D	Residents Requiring Gastrostomy Care - NAC 449.271 Residents requiring gastrostomy care or suffering from staphylococcus infection or other serious infection or medical condition. (NRS 449.0302) Except as otherwise provided in NAC 449.2736, a person must not be admitted to a residential facility or permitted to remain as a resident of a residential facility if he or she: 1. Except as otherwise provided in subsection 2 and NAC 449.2736, a person must not be admitted to a residential facility or permitted to remain as a resident of a residential facility if he or she: (a) Requires gastrostomy care; (b) Suffers from a staphylococcus infection or other serious infection; or (c) Suffers from any other serious medical condition that is not described in NAC 449.2712 to 449.2734, inclusive. 2. If a governmental entity with jurisdiction, including, without limitation, a local board of health, a local health officer, the Division, the Chief Medical Officer or the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, declares the existence of an epidemic or pandemic, a residential facility located in the area in which the epidemic or pandemic is occurring may permit a resident suffering from a serious infection to remain a resident if the resident does not have symptoms that require a higher level of care than the residential facility is capable of providing.	0680	1. After the survey, the Administrator had consulted Health Care Providers whether an Adult Group Care can take care of a Resident that needs PEG TUBE Feeding. I have consulted a Nurse from another Hospice Agency and a Doctor from Renown Hospital. According to them: an Adult Group Care can only take care of a resident on PEG TUBE Feeding if the Nurse from the Hospice Agency will do the feeding. The reason they said is that: Before administering the PEG TUBE Health Care Provider has to assess whether there is a constipation on the tube that can cause aspiration to the resident and only Health Care Provider has the capacity to assess that. On August 21, 2024 Administrator had contacted the Hospice Agency that is in-charge of the care of Resident 2: He discussed with them that the facility can only continue to take care of Resident 2 if PEG TUBE Feeding will be administered by their Nurse on a daily basis twice a day - 8:00am and 5:00pm. On 08/22/2024 they decline the administrator's request - stating that Hospice Nurse can only visit the facility once a week. The Hospice representative said that they will help us find a Skilled Nursing Facility to cater to the higher acuity of care of the	09/05/2024

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 _____	08/14/2024

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
	Inspector Comments: Based on observation, interview, record review, and document review, the facility failed to ensure a resident requiring gastrostomy care had an approved medical exemption prior to admission to the facility for 1 of 9 residents (Resident #2). Findings include: Resident #2 Resident #2 was admitted to the facility on 02/11/2024, with diagnoses including Parkinson's disease and muscle weakness. A Physician's Medical Evaluation for Assisted Living, dated 02/10/2024, documented Resident #2 had a Percutaneous Endoscopic Gastrostomy (PEG) tube (a tube passed into the stomach through the abdominal wall). The resident was bed bound and required tube feeding. The resident needed total help with ambulating, bathing, dressing, grooming, and transferring. On 08/14/2024 at 10:20 AM, Caregiver1 verbalized the caregiver would crush the resident's medications, mix the medications with the resident's prescribed tube feeding formula and put the medications and formula through the resident's PEG tube with some water. Caregiver2 provided undated documentation of a bedfast waiver application for Resident #2. Caregiver2 verbalized the bedfast waiver had been submitted on 08/01/2024. Caregiver2 verbalized the caregiver had included the resident's PEG tube in the waiver. On 08/14/2024 at 10:25 AM, Resident #2 explained the caregivers in the facility administered the medications and the tube feeding through the resident's PEG tube. The resident confirmed the resident did not assist the caregivers with the administration of the medications or administer the medications themself. The August 2024 Medication Administration Record for Resident #2 documented the following medications were initialed as administered via the resident's PEG tube by caregivers in the facility: - Carbidopa-Levodopa 25-250 milligrams (mg), take one tablet via PEG tube twice a day for Parkinson's disease. - Trazodone Hydrochloride 50 mg, take one tablet by mouth daily at bedtime for difficulty sleeping. - Osmolite 8-ounce nutritional drink, three times daily. On 08/14/2024 at 10:53 AM, a representative for the hospice		resident. On 08/28/2024 Resident 2 was hospitalized due to severe coughing with the suspicion that it is due to PEG TUBE Feeding. Administrator had coordinated with the hospital that Resident 2 needs a higher level of care like Skilled Nursing Facility when he discharges and they agreed and thus Resident 2 was discharged from the facility 0n 08/28/2024. see attachment 1 2. On August 22, 2024 Administrator reoriented all managers of the facility (Caregiver 2, 4 & 5) re: the Interpretative Guidelines in Admitting Residents in An Adult Group Care so that they are aware of the qualifications of each residents that the facility can and cannot admit. see attachment 2. Administrator also asked them to consult him regarding the resident's care before admission. 3. Administrator will monitor the Facility's residents and their care on a regular basis. He will do this every end of the month starting August 31, 2024 and every end of the month thereof. In his absence Caregiver 4 will do the monitoring.	

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 _____	08/14/2024

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
	agency providing services to the resident verbalized the hospice nurse visited the resident one time a week and the hospice was not providing daily visits for medication administration. On 08/14/2024 at 11:10 AM, Caregiver2 verbalized Caregiver2 did not realize the facility staff were not able to administer medications via a PEG tube and confirmed the facility staff had been administering the resident's medications. Caregiver2 confirmed the facility had not applied for a waiver until 08/01/2024. Severity: 2 Scope: 1			

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 _____	08/14/2024

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
0859 SS= E	Medical Care of Resident After Illness - NAC 449.274 and R043-22 Medical care of resident after illness, injury or accident; periodic physical examination of resident; rejection of medical care by resident; written records. (NRS 449.0302) 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by a qualified provider of health care in accordance with NRS 449.1845. The resident must be cared for pursuant to any instructions provided by the qualified provider of health care. Inspector Comments: Based on interview and record review, the facility failed to ensure an initial general physical examination with a review of systems was completed 3 of 8 residents (Resident #1, #4, and #7). Findings include: Resident #1 Resident #1 was admitted to the facility on 10/23/2023, with diagnoses including cognitive decline and chronic obstructive pulmonary disease. The record for Resident #1 lacked a general physical examination completed prior to admission. Resident #4 Resident #4 was admitted to the facility on 10/12/2023, with diagnoses including enlarged prostate and occluded urinary catheter. The record for Resident #4 lacked a general physical examination completed prior to admission. Resident #7 Resident #7 was admitted to the facility on 09/28/2023, with diagnoses including seizure, muscle weakness, and falls. The record for Resident #7 lacked a general physical examination completed prior to admission. On 08/14/2024 at 12:40 PM, a Caregiver confirmed the facility did not have initial general physical examinations completed prior to admission for Residents #1, #4, and #7. Severity: 2 Scope: 2	0859	1. After the survey; Administrator immediately contacted Hospice Service of Reno to provide General Physical Exam Notes for Resident 1 before she was admitted on 10/23/2023. They provided her Progress Notes dated 08/29/2023 see attachment no. 1 Request was also made to the Doctor of Resident 4 for his General Physical Exam Prior to admission on 10/12/2023 - On 08/26/24 They provided us his Progress Note dated 02/19/2023 see attachment no. 2 Finally, Resident 7's Physician's notes was misfiled and was put back on her file see attachment no. 3. 2. As I have mentioned reorientation seminar was given to the caregivers as to guidelines and completion of Resident files so as not to repeat same deficiency. see tag 0515 attachment for the caregivers reorientation seminar 3. Administrator will monitor all facility files every end of the month starting August 31, 2024 and every end of the month thereof. 4. In his absence Caregiver 4 will do the monitoring.	09/06/2024
0870 SS= E	Medication Administration-Accuracy & Report - NAC 449.2742 Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall:	0870	1. After the survey, Administrator signed the Pharmacy review of Resident 1, 2, & 4 with the note that "It was only corrected as per SOD on 8/14/24". 2. The administrator advised Caregiver 2 and 5 that in the administrator's absence	09/06/2024

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 _____	08/14/2024

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
	(a) Ensure that a physician, pharmacist or registered nurse who does not have a financial interest in the facility: (1) Reviews for accuracy and appropriateness, at least once every 6 months the regimen of drugs taken by each resident of the facility, including, without limitation, any over-the-counter medications and dietary supplements taken by a resident; and (2) Provides a written report of that review to the administrator of the facility. (b) Include a copy of each report submitted to the administrator pursuant to paragraph (a) in the file maintained pursuant to NAC 449.2749 for the resident who is the subject of the report. (c) Make and maintain a report of any actions that are taken by the caregivers employed by the facility in response to a report submitted pursuant to paragraph (a). Inspector Comments: Based on interview and record review, the Administrator failed to ensure a Pharmacy Review was completed at least once every six months for 3 of 8 residents in the facility longer than six months (Residents #1, #2, and #4). Findings include: Resident #1 Resident #1 was admitted to the facility on 10/23/2023, with diagnoses including cognitive decline and chronic obstructive pulmonary disease. Resident #1's record lacked a Pharmacy Review completed on or before 04/23/2024. Resident #2 Resident #2 was admitted to the facility on 02/11/2024, with diagnoses including Parkinson's disease and muscle weakness. Resident #2's record lacked a Pharmacy Review completed on or before 08/11/2024. Resident #4 Resident #4 was admitted to the facility on 10/12/2023, with diagnoses including enlarged prostate and obstructed urinary catheter. Resident #4's record lacked a Pharmacy Review completed on or before 04/12/2024. On 08/14/2024 at 12:40 PM, a Caregiver confirmed the facility did not have six-month Pharmacy Reviews for Residents #1, #2, and #4). Severity: 2 Scope: 2		and as his DESIGNEE; they can sign the Medication Review when the administrator is not available. In this case, Facility has updated documentation that facility is aware of the recent reviews of the Resident's medications and whatever changes to their medications are being implemented and noted by the facility. To supplement the administrator's advice - On August 18, 2024 Administrator did a reorientation seminar on Medication Management for all the caregivers so as not to repeat the deficiency again. see attachment no. 2 3. Administrator will monitor the Resident's Files every end of the month starting August 31, 2024 and every end of the month thereof. 4. In his absence Caregiver 4 will do the monitoring.	
0895 SS= D	Administration of Medication Maintenance - NAC 449.2744 and R043-22 Administration of medication: Maintenance and contents of logs and records. (NRS 449.0302) 1. The	0895	1. Resident 1 MAR was corrected on 08/14/2024 with the note that it was corrected per SOD dtd8/14/24.	09/06/2024

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 _____	08/14/2024

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
	administrator of a residential facility that provides assistance to residents in the administration of medications shall maintain: (b) A record of the medication administered to each resident. The record must include: (1) The type of medication administered; (2) The date and time that the medication was administered; (3) The date and time that a resident refuses, or otherwise misses, an administration of medication; (4) Instructions for administering the medication to the resident that reflect each current order or prescription of the resident's physician, physician assistant or advanced practice registered nurse, including, without limitation, whether the medication is to be administered according to a routine schedule or as needed; (5) Any change in an order or prescription of a resident ' s physician, physician assistant or advanced practice registered nurse,including, without limitation, the discontinuation of the medication; (6) Any time when the resident is out of the facility; and (7) Any mistakes made in the administration of medication. Inspector Comments: Based on interview and record review, the facility failed to ensure the Medication Administration Record (MAR) was accurate for 1 of 8 residents (Resident #1). Findings include: Resident #1 Resident #1 was admitted to the facility on 10/23/2023, with diagnoses including cognitive decline and chronic obstructive pulmonary disease. On 08/15/2024 at 10:50 AM, during a review of Resident #1's medication the following discrepancy was observed: - A medication order dated 06/24/2024, and the label on the medication on site documented, Acetaminophen 325 milligrams (mg), take two tablets by mouth every six hours as needed for fever/mild pain. - the August 2024 MAR documented Acetaminophen 500 mg, take one tablet by mouth every six hours as needed for pain. On 08/14/2024 at 10:54 AM, a Caregiver confirmed the Acetaminophen order had been transcribed incorrectly on the MAR. Severity: 2 Scope: 1		2. Administrator had counseled Caregiver 2 to be very careful in printing the Medications of all the Residents in the MAR. I cautioned him that whatever Medications and dosage that is reflected in the MAR will be tantamount to the actual Medications and dosage that we are administering to the residents. Medication reorientation seminar was given to all caregivers on August 18, 2024 emphasizing the accurateness of the MAR as per resident's prescriptions and medications. see attachment on tag 0870 3. Administrator will monitor the MAR every end of the month starting August 31, 2024 and every end of the month thereof. 4. In his absence Caregiver 4 will do the monitoring.	
1600 SS= C	Preferred Name/Pronoun P& P - Preferred Name/Pronoun P& P R016-20 Sec. 19 1. A	1600	1. On August 15, 2024 Administrator Made an amendment to all existing Resident's	09/06/2024

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 _____	08/14/2024

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
	facility shall: (a) Develop policies to ensure that a patient or resident is addressed by his or her preferred name and pronoun and in accordance with his or her gender identity or expression; and (b) Adapt electronic records and any paper records the facility has to reflect the gender identities or expressions of patients or residents with diverse gender identities or expressions, including, without limitation: (2) If the facility is a facility for the dependent or other residential facility, adapting electronic records and any paper records the facility has to include the preferred name and pronoun and gender identity or expression of a resident. R016-20 Sec. 19 2. If a patient or resident chooses to provide the following information, the health records adapted pursuant to subparagraph (1) of paragraph (b) of subsection 1 must include, without limitation: (a) The preferred name and pronoun of the patient or resident; (b) The gender identity or expression of the patient or resident; (c) The gender identity or expression of the patient or resident that was assigned at the birth of the patient or resident; (d) The sexual orientation of the patient or resident; and (e) If the gender identity or expression of the patient or resident is different than the gender identity or expression of the patient or resident that was assigned at the birth of the patient or resident: (1) A history of the gender transition and current anatomy of the patient or resident; and (2) An organ inventory for the patient or resident which includes, without limitation, the organs: (I) Present or expected to be present at the birth of the patient or resident; (II) Hormonally enhanced or developed in the patient or resident; and (III) Surgically removed, enhanced, altered or constructed in the patient or resident. R016-20 Sec. 20 1. Except as otherwise provided in subsection 2, the statements, notices and information required by sections 2 to 22, inclusive, of this regulation and NRS 449.101 to 449.104, inclusive, must be in English and, as appropriate for a facility, in any other language the Department determines is appropriate based on the demographic characteristics of this State. In addition to the notices and information		Admission; He added a document re: Resident's Preferences as to name, pronouns, gender identity and sexual orientation see attachment. 1 2. On August 20, 2024 Administrator gave a seminar regarding: requirements on Record Keeping as to Resident files, employee files and other facility forms. In the seminar it tackles about the Cultural Competency seminar that all caregivers had taken, that it is necessary for the facility to know before admitting residents their preferred names, pronouns, gender identity and sexual orientation so that we can addressed them properly. see attachment 2 for the seminar. 3. August 31, 2024 Administrator had monitored the facility files and made sure that it is complete and in compliance with the BHCQC regulations. He will regularly do this every end of the month. 4. In his absence, Caregiver 4 will do the monitoring.	

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 _____	08/14/2024

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
	provided in English and any other language the Department determines is appropriate based on the demographic characteristics of this State, a facility may provide the statements, notices and information in any other language the facility may desire. R016 -20 Sec. 20 2. A facility must make reasonable accommodations in providing the statements, notices and information described in subsection 1 for patients or residents who: (a) Are unable to read; (b) Are blind or visually impaired; (c) Have communication impairments; or (d) Do not read or speak English or any other language in which the statements, notices and information are written pursuant to subsection 1. Inspector Comments: Based on record review and interview, the facility failed to ensure there were policies developed and resident records in compliance with R016-20 Section 19, regarding resident records to reflect a resident's preferred name, pronoun, gender identity or expression, and sexual orientation, affecting 8 of 8 residents (Residents #1, #2, #3, #4, #5, #6, #7, and #8). Findings include: Resident #1 Resident #1 was admitted to the facility on 10/23/2023, with diagnoses including cognitive decline and chronic obstructive pulmonary disease. Resident #2 Resident #2 was admitted to the facility on 02/11/2024, with diagnoses including Parkinson's disease and muscle weakness. Resident #3 Resident #3 was admitted to the facility on 07/01/2024, with diagnoses including seizures and nerve pain. Resident #4 Resident #4 was admitted to the facility on 10/12/2023, with diagnoses including enlarged prostate and occluded urinary catheter. Resident #5 Resident #5 was admitted to the facility on 09/20/2023, with diagnoses including nausea, dehydration, and weakness. Resident #6 Resident #6 was admitted to the facility on 05/16/2024, with a diagnosis of dementia. Resident #7 Resident #7 was admitted to the facility on 09/28/2023, with diagnoses including seizure, muscle weakness, and falls. Resident #8 Resident #8 was admitted to the facility on 04/04/2024, with diagnoses including chronic kidney disease stage five			

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 _____	08/14/2024

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
	and dialysis. On 08/14/2024, in the morning, the records for Residents #1, #2, #3, #4, #5, #6, #7, and #8 lacked documentation to be in compliance with R016-20 Section 19. On 08/14/2024 at 12:40PM, a Caregiver confirmed there were no changes to resident records in compliance with the regulation. Severity: 1 Scope: 3			