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
	7195	A. BUILDING _____ B. WING _____	02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT PAUL HOME CARE III	4910 KOENIG RD, RENO, NEVADA ,89506

(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 in your facility on 02/02/23. This State Licensure survey was conducted by the Division of Public and Behavioral Health in accordance with NAC 449, Residential Facility for Groups. The facility was licensed for ten Residential Facility for Group beds for elderly and disabled persons and/or persons with mental illness, with three beds for low income, three Category 1 and seven Category II residents. The census at the time of survey was seven. Seven resident files and four employee files were reviewed. The facility received a grade of D. 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 investigation, 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: JERIS BELTEJAR Title: Owner Date: 06/20/2023

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0102 SS= F	Personnel File - TB Screening - NAC 449.200 Personnel files. 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (d) The health certificates required pursuant to chapter 441A of NAC for the employee; Inspector Comments: Based on personnel file review, document review, and interview, the facility failed to ensure an employee met the requirements concerning tuberculosis (TB) testing per NAC 441 for 3 of 4 sampled employees (Employee #2, 3, and #4). Findings include: Employee #2 Employee #2 was hired as the Owner with a start date of 12/01/11. Employee #2's personnel record documented an annual TB signs and symptoms on 05/18/21. Employee #2's personnel record lacked documented evidence of an annual TB signs and symptoms for 2022. On 02/02/23 at 3:18 PM, the Owner confirmed Employee #2 lacked documented evidence of an annual TB signs and symptoms for 2022. Employee #3 Employee #3 was hired as an Caregiver with a start date of 04/15/20. Employee #3's personnel record documented a first step TB test read negative on 03/12/20 and a second step TB test read negative on 03/20/20. Employee #3's personnel record lacked documented evidence of an annual TB test for 2021 and 2022. On 02/02/23 at 3:22 PM, the Owner confirmed Employee #3 lacked documented evidence of an annual TB test for 2021 and 2022. Employee #4 Employee #4 was hired as the Caregiver with a start date of 06/15/14. Employee #4's personnel record documented an annual TB signs and symptoms on 06/18/21. Employee #4's personnel record lacked documented evidence of an annual TB signs and symptoms for 2022. On 02/02/23 at 3:28 PM, the Owner confirmed Employee #4 lacked documented evidence of an annual TB signs and symptoms for 2022. Severity: 2 Scope: 3	0102	Employee #2 andemployee #3 received a new annual TB Signs and Symptoms on 2/10/2023. Employee #3 is scheduled to receive a first stepTB skin test on 3/30/2023. A second stepTB skin test will be scheduled a week after their first step TB test has beenread. The facility administrator willutilize an employee file checklist to ensure that all employees receive theirannual TB skin test/ signs and symptoms on or prior to the anniversary date oftheir last TB test/ signs and symptoms to ensure annual compliance of the requiredtesting.	03/30/2023

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0106 SS= D	Personnel File - 1st Aid & CPR - NAC 449.200 Personnel files 2. The personnel file for a caregiver of a residential facility must include, in addition to the information required pursuant to subsection 1: (a) A certificate stating that the caregiver is currently certified to perform first aid and cardiopulmonary resuscitation; Inspector Comments: Based on employee personnel file review and interview, the facility failed to ensure 1 of 4 sampled employees (Employee #2) maintained current certification in cardiopulmonary resuscitation (CPR) and first aid training. Findings include: Employee #2 Employee #2 was hired as an Owner/Caregiver with a start date of 12/01/11. Employee #2's personnel file lacked documented evidence of current CPR and first aid certification. On 12/09/22 at 3:18 PM, the Owner was unable to provide evidence of current CPR and first aid certification for Employee #2. Severity: 2 Scope: 1	0106	The facilityadministrator acknowledges that the CPR & First Aid training for Employee #2is late. Employee #2 ha been scheduledto renew their CPR & First Aid Training on 4/11/2023. Until then, employee #2 is not scheduled towork at the facility unless accompanied by another caregiver with the completedCPR & First Aid training. Thefacility administrator will utilize an employee file checklist to ensure thatall employees receive their annual CPR & First Aid training on or prior tothe anniversary date of their last CPR & First Aid training as to not lettheir training lapse.	04/11/2023

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0620 SS= D	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 record review and interview, the facility failed to ensure a resident receiving skilled nursing services was not allowed to admit or remain in the facility for 1 of 7 residents receiving skilled nursing services (Resident #4). Findings include: Resident #4 Resident #4 was admitted to the facility on 05/03/21, with a diagnosis of non-healing wound of left lower extremity, cognitive impairment and chronic pain. On 02/02/23 at 12:05 PM, the Owner of the facility had the resident receiving skilled nursing care through home health. The Owner explained the Owner was not aware of the requirement to submit waivers to the State Agency for residents receiving skilled nursing care. The Owner confirmed the facility had not submitted waivers to the State Agency to retain residents receiving skilled nursing care. Severity: 2 Scope: 1	0620	Resident #4 wasdischarged from their respective home health agency and is no longer requiring woundcare. The facility administrator hascontacted the bureau on proper steps on how to apply for a waiver for residentsreceiving skilled nursing or hospice services provided by an outside agency shouldany future or current resident require such a waive. The facility administrator will ensure that awaiver is applied for and completed for any future residents requiring skillednursing or hospice services.	03/20/2023

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0644 SS= C	Posting Requirements - 1. A person who operates a residential facility for groups shall: (a)?Post his or her license to operate the residential facility for groups; (b)?Post the rates for services provided by the residential facility for groups; and (c)?Post contact information for the administrator and the designated representative of the owner or operator of the facility, in a conspicuous place in the residential facility for groups. Inspector Comments: Based on observation and interview, the facility failed to ensure the current grade placard was posted. Findings include: On 02/02/23 at 10:00 AM, during the initial tour of the facility, the facility grade placard was observed in the living room of the facility, and was not the correct current grade placard. On 02/02/23 at 10:09 AM, the Owner confirmed the facility grade placard was observed in the living room of the facility, and was not the correct current grade placard. Severity: 1 Scope: 3	0644	The current gradeplacard has been received and placed in place of the old grade placard. The facility administrator will ensure thatthe most current grade placard is hung in the facility as soon as it isreceived from the bureau.	03/20/2023
0859 SS= F	Medical Care of Resident After Illness - NAC 449.274 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 his or her physician. The resident must be cared for pursuant to any instructions provided by the resident ' s physician. Inspector Comments: Based on interview and record review, the facility failed to ensure a physical examination including a review of systems was completed annually for 5 of 7 residents (Resident #1, #2, #3, #4 and #5). Findings include: Resident #1 Resident #1 was admitted to the facility on 03/17/17 with a diagnosis of degeneration of nervous system. Resident #1's record documented a physical examination dated 05/20/21. The resident's record lacked documented evidence of an annual physical	0859	The facilityhas contacted the primary care provider’s office for and received H&P's forresident's #1, 2, 3, and 4. The physician’s office has informed thefacility that all records going forward will only be available digitally. The facility has submitted the paperwork to the PCP’s office to establish anonline account in which all future and prior H&Ps for each resident can beaccessed. The facility administrator acknowledgesthat no H&P was available for resident #4 at the time of admission. Going forward, the facility administrator willensure that an H&P is made available to the facility at the time of admittancefor any future resident. The facilityadministrator will also ensure that each resident’s progress notes areaccessible through the new PCP’s online portal, printed, and filed in their respectivecharts at the facility.	03/20/2023

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	examination with a review of systems for 2022. Resident #2 Resident #2 was admitted to the facility on 10/13/20 with diagnoses of aggression and neurocognitive disorder. Resident #2's record documented a physical dated 08/26/21. The resident's record lacked documented evidence of an annual physical examination with a review of systems for 2022. Resident #3 Resident #3 was admitted to the facility on 05/02/13 with diagnoses of hypertension and agitation. Resident #3's record documented a physical dated 07/22/21. The resident's record lacked documented evidence of an annual physical examination with a review of systems for 2022. Resident #4 Resident #4 was admitted to the facility on 05/03/21 with diagnoses of non-healing wound of left lower extremity and cognitive impairment. Resident #4's record documented a physical dated 08/26/21. The resident's record lacked documented evidence of an annual physical examination with a review of systems for 2022. Resident #5 Resident #5 was admitted to the facility on 11/15/22 with diagnoses of osteoarthritis, depression and anxiety. Resident #5's record documented a physical dated 01/20/23. The resident's record documented an initial physical examination completed after the residents admission. On 02/02/23 at 12:00 PM, the Owner confirmed an annual physical examination with a review of systems was not completed for Resident #1, #2, #3, #4, and #5 in 2022. Severity: 2 Scope: 3			

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0876 SS= D	Medication Administration - NRS 449.0302 - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. (as amended by LCB File No. R109-18) 4. Except as otherwise provided in this subsection, a caregiver shall assist in the administration of medication to a resident if the resident needs the caregiver's assistance. A caregiver may assist the ultimate user of: (a) Controlled substances or dangerous drugs only if the conditions prescribed in subsection 6 of NRS 449.0302 are met. (b) Insulin using an auto-injection device only if the conditions prescribed in NRS 449.0304 and section 13 of this regulation are met. Inspector Comments: Based on clinical record review and interview, the Administrator failed to ensure a resident had a valid Ultimate User Agreement authorizing the facility to store and administer medications for 1 of 7 sampled residents (Resident #5). Resident #5 Resident #5 was admitted to the facility on 11/15/22, with diagnoses including osteoarthritis, depression and anxiety. Resident #5's clinical record documented an Ultimate User Agreement Request and Authorization for Medical Supervision and Assistance, was signed and undated. On 02/02/23 at 12:00 PM, a Owner confirmed the facility stored and administered medications for Resident #5. The Owner verbalized the Ultimate User Agreement was invalid due to the form lacking a date. Severity: 2 Scope: 1	0876	Resident #5 hasfilled out, signed, and dated a new Ultimate User Agreement for the facilityallowing them to store and administer their medications. The facility administrator will ensure thatall signed documents in the future are not only signed but also dated by theresident when admitting them to the facility.	03/20/2023
0936 SS= F	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	0936	Resident #3 receiveda new annual TB Signs and Symptoms on 2/10/2023. Residents #1, 2, 5, 6, and 7 are scheduled toreceive a first step TB skin test on 3/30/2023. A second step TB skin test will be scheduled a week after their firststep TB test has been read. The facilityadministrator will utilize a resident file checklist to ensure that all residentsreceive their annual TB skin test/ signs and symptoms on or prior to theanniversary date of their last TB test/ signs and symptoms to ensure annualcompliance of the required	03/30/2023

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	limitation: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. Inspector Comments: Based on clinical record review and interview, the facility failed to ensure 6 of 7 sampled residents met the requirements for timely tuberculosis (TB) testing in accordance with Nevada Administrative Code (NAC) 441A (Resident #1, #2, #3, #5, #6, and #7). Findings include: Resident #1 Resident #1 was admitted to the facility on 03/17/17, with a diagnosis including degeneration of nervous system. Resident #1's clinical record documented a one step TB test given 05/20/20 and read negative on 05/22/20. The resident's record lacked documented evidence of an annual TB test completed in 2021 and 2022. Resident #2 Resident #2 was admitted to the facility on 10/13/20, with a diagnosis including aggression and neurocognitive disorder. Resident #2's clinical record documented a QuantiFERON dated 07/17/20. The resident's record lacked documented evidence of an annual TB test completed in 2021 and 2022. Resident #3 Resident #3 was admitted to the facility on 05/02/13, with a diagnosis including hypertension and agitation. Resident #3's clinical record documented a negative chest x-ray dated 03/28/21. The resident's record lacked documented evidence of an annual TB signs and symptoms completed in 2022. Resident #5 Resident #5 was admitted to the facility on 11/15/22, with a diagnosis including osteoarthritis and anxiety. Resident #5's clinical record lacked documented evidence of an initial TB test. Resident #6 Resident #6 was admitted to the facility on 01/28/23, with a diagnosis including hypothyroidism, dementia, and prostate cancer. Resident #6's clinical record lacked documented evidence of an initial TB test. Resident #7 Resident #7 was admitted to the facility on 02/01/23, with a diagnosis including obstructive sleep apnea, psoriasis, and muscle weakness. Resident #7's clinical record lacked documented evidence of an initial TB test. On 02/02/23 at 11:55 AM, the Owner confirmed Resident #1, #2, #3, #5, #6, and #7 lacked timely TB testing and		testing.	

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	verbalized all residents were required to completed a two-step TB test upon admission to the facility and one step TB test annually thereafter. Severity: 2 Scope: 3			
0938 SS= F	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: (g) An evaluation of the resident ' s ability to perform the activities of daily living and a brief description of any assistance he or she needs to perform those activities. The facility shall prepare such an evaluation: (1) Upon the admission of the resident; (2) Each time there is a change in the mental or physical condition of the resident that may significantly affect his or her ability to perform the activities of daily living; and (3) In any event, not less than once each year. Inspector Comments: Based on interview and document review, the facility failed to ensure initial and annual Activities of Daily Living (ADL) Assessments were completed for 5 of 7 sampled residents (Resident #1, #2, #3, #4, #6). Findings include: Resident #1 Resident #1 was admitted to the facility on 03/17/17, with a diagnosis including degeneration of nervous system. Resident #1's clinical record documented an ADL assessment completed 09/17/21, and lacked documented evidence an annual ADL assessment was completed in 2022. Resident #2 Resident #2 was admitted to the facility on 10/13/20, with a diagnosis including aggression and neurocognitive disorder. Resident #2's clinical record documented an ADL assessment completed 10/13/21, and lacked documented evidence an annual ADL	0938	New ADL Assessmentshas been completed for resident’s #1, 2, 3, 4, and 6 on 2/11/2023. The facility administrator will ensure thatall residents have a new ADL assessment completed should any changes in theresident’s daily care needs change, or on or before every 12 months upon thelast previously completed ADL assessment.	03/20/2023

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	assessment was completed in 2022. Resident #3 Resident #3 was admitted to the facility on 05/02/13, with a diagnosis including hypertension and agitation. Resident #3's clinical record documented an ADL assessment completed 11/02/21, and lacked documented evidence an annual ADL assessment was completed in 2022. Resident #4 Resident #4 was admitted to the facility on 05/03/21, with a diagnosis including chronic pain, non-healing wound of left lower extremity, and cognitive impairment. Resident #4's clinical record documented an ADL assessment completed 11/04/21, and lacked documented evidence an annual ADL assessment was completed in 2022. Resident #6 Resident #6 was admitted to the facility on 01/28/23, with a diagnosis including hypothyroidism, dementia, and prostate cancer. Resident #6's clinical record documented an ADL assessment completed 02/01/23, three days after resident #6's admission. On 02/02/23 at 12:11 PM, the Owner confirmed resident #1, #2, #3, #4 and #6 did not have timely completed ADL assessments. The Owner verbalized the ADL assessments needed to be completed initially and annually for the residents. Severity: 2 Scope: 3			

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1540 SS= F	Cultural Competency Training Inspector Comments: Based on personnel record review and interview, the facility failed to ensure 1) cultural competency training was completed timely for 1 of 4 employees (Employees #1), and 2) an employee had completed a cultural competency course approved by the Division of Public and Behavioral Health for 3 of 4 employees (Employee #2, #3, and #4). Findings include: Employee #1 Employee #1 was hired as an Administrator with a start date of 12/01/11. The personnel record for Employee #1 had a cultural competency training certificate dated 10/10/22. On 02/02/23 at 3:18 PM, the Caregiver confirmed the cultural competency training for Employee #1 was completed late. Employee #2 Employee #2 was hired as an Owner on 12/01/11. The personnel record for Employee #2 lacked documented evidence the employee had completed a cultural competency course. Employee #3 Employee #3 was hired as a Caregiver on 04/15/20. The personnel record for Employee #3 lacked documented evidence the employee had completed a cultural competency course. Employee #4 Employee #4 was hired as a Caregiver on 06/15/14. The personnel record for Employee #4 lacked documented evidence the employee had completed a cultural competency course. On 02/02/23 at 3:22 PM, the Owner confirmed the personnel records lacked evidence the employees #2, #3, and #4 had completed a cultural competency course. Severity: 2 Scope: 3	1540	The facilityadministrator acknowledges that the Cultural Competency training for Employee #1was completed late. Employee #2 and 3 hasbeen scheduled to complete their Cultural Competency training on 4/12/2023. Employee #4 has been scheduled to completetheir Cultural Competency training on 4/14/2023. The facility administrator will utilize anemployee file checklist to ensure that all employees receive their annual CulturalCompetency training on or prior to the anniversary date of their last CulturalCompetency training as to not let their training lapse.	04/14/2023

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SAINT PAUL HOME CARE III	4910 KOENIG RD, RENO, NEVADA ,89506

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1700 SS= D	Annual Assessment of History of Each Resident Inspector Comments: Based on record review and interview, the Administrator failed to obtain a complete and accurate Standard Physician Assessment and Placement Determination for 1 of 7 residents (Resident #7). Findings include: Resident #7 Resident #7 was admitted to the facility on 02/01/23, with diagnoses including obstructive sleep apnea, psoriasis, and muscle weakness. Resident #7's clinical record lacked documented evidence a Standard Physician Assessment and Placement Determination had been completed. On 02/02/23 at 11:55 AM, the Owner confirmed a Standard Physician Assessment and Placement Determination had not been completed for Resident #7 and verbalized was responsible to ensure all admission documents were accurately and entirely completed. Severity: 2 Scope: 1	1700	A PhysicianPlacement Determination has been submitted to and filled out by resident #7's PCPstating that the resident is appropriate to stay in their current group home setting. The facility administrator will utilize a residentfile checklist to ensure that all residents receive their annual PhysicianPlacement Determination assessment on or prior to the anniversary date of theirlast Physician Placement Determination assessment as to not let the time framebetween assessments go over 12 months.	03/20/2023