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 _____	**01/31/2020**

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

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation initiated at your facility on 01/24/20 and finalized on 01/31/20. This complaint investigation was conducted in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is 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 8. The sample size was nine residents, including the resident of concern. There was one complaint investigated. Complaint #NV00059871 with the following allegations could not be unsubstantiated. Allegation #1: Facility staff neglected basic care for the resident, failing to provide and/or monitor hydration. Allegation #2: Facility staff neglected basic care for the resident, failing to ensure the resident was kept warm. Allegation #3: Facility staff failed to notice symptoms of failure to thrive and sepsis. The investigation into the allegations included: Observations included a tour of the facility and observations of interactions between staff and residents. Interviews were conducted with the Administrator, Assistant Administrator, Activities Coordinator, five residents, two Caregivers, a hospice intake specialist, and the Guardian Case Manager of the resident of concern. Nine resident records were reviewed, including the resident of concern. Five employee records were reviewed. Documents reviewed were: menus, employee work schedules, incident/accident reports, evacuation map, hospice referral notes, visitors log, and home health physical therapy notes. The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be construed as	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | Name: ERNESTO BELTEJAR JR. | Title: ADMINISTRATOR | Date: 02/23/2020

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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	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:			
0088 SS= C	Staffing Schedule - NAC 449.199 Staffing requirements 4. The administrator of a residential facility shall maintain monthly a written schedule that includes the number and type of members of the staff of the facility assigned for each shift. The schedule must be amended if any changes are made to the schedule. The schedule must be retained for at least 6 months after the schedule expires. Inspector Comments: Based on document review, observation, and interview, the Administrator failed to ensure staff schedules were correct, clearly listing the staff who actually worked on 12/31/19 and 01/01/20, listed the hours of each shift, updated after staff members changed shifts and no longer were employed at the facility, and kept at the facility for six months. Findings include: A review of the staff schedule for December 2019 and the first four days of January 2020 revealed: - Caregiver #1 and Caregiver #2 were scheduled on "duty" for the day shift and Caregiver #3 was scheduled on "duty" for the night shift on Tuesday, 12/31/19, and for Wednesday, 01/01/20 A review of the staff schedule for the last three days of December 2019 and January 2020 revealed: - Caregiver #2 was scheduled "off" for the day shift on Tuesday, 12/31/19. - Caregiver #3 was scheduled "off" for the night shift on Wednesday, 01/01/20. The staff schedules for December 2019 and January 2020 included the terms "day shift" and "night shift." However, they did not indicate the start and stop times for each of these shifts. On 01/24/20 at 12:16 PM, the Activities Coordinator verbalized being responsible for preparing and updating the facility's staff schedules and admitted not	0088	1-2. After the surveyor pointed the deficiencies of Starlight Grouphome, LLc. The Administrator made sure that: a. Schedules were done correctly and updated everyday. He makes sure that whoever caregivers that are scheduled to work on a certain day are the ones that are working. He is checking this by either visiting or calling the facility everyday. b. He changed the format of the schedule; started on February 1, 2020; the schedule reflected the time of work of each caregivers: caregiver 1 was assigned from 6:00am to 6:00pm, caregiver 2 has to work 8:00am to 8:00pm, (Caregiver 1 & 2 has to give each other a break in the morning and afternoon); caregiver 3 has to work 8:00pm to 6:00am. see attachment no. 1 for the Schedules. c. He made sure that current Schedules are posted on the wall and after it is done (after a month), it should be kept in a binder for six months named: SCHEDULES and pointed to the caregivers the location of the Binder - so that they know where to see it if they need references. see attachment no. 2 3-4 The administrator is monitoring the schedules everyday by either visiting the facility or by calling the facility to makes sure that the right staff on schedule is the one working on that day. In his absence, the manager/designee of the facility is the one in charge of the schedule and monitoring. He took this duty out from the activity coordinator so that, he can closely monitors the schedule. 5. Schedules had been corrected started on February 1, 2020 and being monitored daily.	02/23/2020

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	updating the calendars for 12/31/19 and 01/01/20. On 01/24/20 at 12:16 PM, the Administrator verbalized the two work schedule calendars had different entries for 12/31/19 and 01/01/20, making unclear who actually had worked those days. The Administrator verbalized the importance of promptly revising the staff schedule when needed. On 01/24/20 at 1:45 PM, Caregiver #2 verbalized having worked the day shift on 01/01/20. On 01/31/20, a request for copies of the October 2019 and November 2019 staff schedules were not available at the facility. On 01/31/20 at 3:15 PM, Caregiver #1, who was acting as Administrator in Charge at the time, verbalized not knowing where the staff schedules for October 2019 and November 2019 were located. A review of the staff schedule for January 2020 indicated Caregiver #3 was scheduled to work the day shift on 01/31/20. On that day, Caregiver #3 was not at the facility. On 01/31/20 at 4:20 PM, the Administrator verbalized Caregiver #3 had not worked at the facility for several weeks and would not be coming back. The Administrator confirmed the facility's staff schedule for January 2020 had not been updated since this caregiver stopped working there. Severity: 1 Scope: 3			
0853 SS= D	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) 3. A written record of all accidents, injuries and illnesses of the resident which occur in the facility must be made by the caregiver who first discovers the accident, injury or illness. The record must include: (a) The date and time of the accident or injury or the date and time that the illness was discovered; (b) A description of the manner in which the accident or injury occurred or the manner in which the illness was discovered; and (c) A description of the manner in which the	0853	1-2. After the incident that happened to Resident no. 9 and after the surveyor pointed to the administrator the importance of a "Documented Incident Report" - the administrator immediately called a meeting to all the staff of the facility. In the meeting, they discussed the importance of Documentation and Incident Report. In the end, the whole staff and administrator agreed to use 2 forms of documentation. One is **Resident log-notes** which the caregiver/s has to write the condition/s of the resident on a daily basis. Before the end of each shift caregiver has to write on the Resident Log Notes regarding his/her observation of all the residents one by one;	02/23/2020

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	members of the staff of the facility responded to the accident, injury or illness and the care provided to the resident. This record must accompany the resident if he or she is transferred to another facility. Inspector Comments: Based on record review and interview, the facility failed to require Caregivers to document resident accidents, injuries, or illnesses occurring in the facility to include date and time, manner of accident or injury and illness discovery, and response and care provided per occurrence for 1 of 9 residents (Resident #9). Resident #9 Resident #9 was admitted to the facility on 04/24/19 with diagnoses including dementia associated with alcoholism. A review of the resident's Medical Administration Record (MAR) for January 2020 revealed the resident had been in the hospital on 01/01/20 through 01/03/20. On 01/24/20 at 3:04 PM, the Activities Coordinator verbalized calling the ambulance company about 9:00 AM for Resident #9 on 01/01/20 after the resident refused to eat, drink, and take medication and expressed pain upon being touched. The Activities Coordinator expressed the resident's feet were cold to the touch. The Activities Coordinator verbalized not writing an incident report for this incident. On 01/24/20, a review of the facility's binder for Incident/Accident Reports uncovered no documented evidence of the 01/01/20 call for an ambulance for Resident #9. On 01/24/20 at 3:41 PM, the Administrator declared staff had called the ambulance company several times for Resident #9 between September and November 2019. The Administrator confirmed no incident/accident reports were on file in the binder for these ambulance calls. The Administrator verbalized the importance of staff documenting each incident and accident at the facility for resident records. Severity: 2 Scope: 1		- whether the resident is ok, not feeling well, called the doctor for this resident, refused medication of resident x, etc. In this case, whatever the caregiver forgets to endorse verbally to the other caregiver, the next caregiver canrefer to the resident log notes. see attachment no. 1 for sample Resident Log Notes. The other documents is the **Incident Report.** They will use these form, if something important has to be addressed, like: hospitalization, falls(accident), sick, agitation, anything that happened to the resident that is not ordinary on the resident's daily routine. On the Incident Report, the administrator also emphasize the importance of filling it up: like the date, the time, the resident, the caregiver/s that gave the intervention, description of the incident, the interventions made by the staff of the facility, then the follow-up, etc. see attachment no. 2 for the Incident Report. In this case, the facility has full documentations of the daily conditions of each resident. 3-4. Administrator had instructed the caregivers on duty that any situations that requires the caregivers to write an incident report - he or the manager of the facility will be notified immediately, so that he has the knowledge of the incident and the Incident Report and can immediately monitor the condition of the resident involved. Also, he will look and review the Facility's Resident Log Notes on a weekly basis to make sure that it is being filled up and endorsed by the caregivers correctly and also, so as the administrator is also updated on all the resident's daily health conditions. 5. Resident Log Notes had started on February 1, 2020 and there are several Incident Reports that had been recorded	

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