

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 6/15/2026
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/20/2023
NAME OF PROVIDER OR SUPPLIER CORINTHIAN PLACE SOUTH LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5855 LONE HORSE DR, RENO, NEVADA ,89502	
(X4) ID PREFIX TAG 0000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG 0000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation initiated at your facility on 06/20/23. This State Investigation was conducted by the Division of Public and Behavioral Health in accordance with NAC 449, Residential Facility for Groups. The facility is licensed for nine Residential Facility for Group beds for the elderly and disabled persons, Category II residents. The census at the time of investigation was eight residents. The sample size was five. The facility received a grade of A. There was one complaint investigated. Complaint #NV00068768 with the following allegations was substantiated: Allegation #1: A weekend caregiver cannot speak English and the staff are not trained on medication management. Allegation #2: The resident's food preferences are not honored. Allegation #3: A resident has unexplained bruises. Allegation #4: A complainant communicated the facility staff criminal background check and training documents were not authentic was substantiated (See Tag Y0104). A deficiency unrelated to the complaint investigation was identified (See Tags Y050, and Y053). 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:			
0050 SS= F	Administrator's Responsibilities - Oversight - NAC 449.194 Responsibilities of administrator. (NRS 449.0302) The administrator of a residential facility shall: 1. Provide oversight and direction for the members of the staff of the facility as necessary to ensure that residents receive needed services and protective supervision and that the facility is in compliance with the	0050	1) How you will correct the specific finding (s) stated in the Statement of Deficiencies (MUST ADDRESS); o Correction Plan: Immediate re-training of all staff on the specific areas of non-	04/07/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER Name: EUGENE GASATAYA Title: ADMINISTRATOR
REPRESENTATIVE'S SIGNATURE

Date: 04/19/2024

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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	requirements of NAC 449.156 to 449.27706, inclusive, and chapter 449 of NRS. Inspector Comments: Based on observation, record review, and interview, the Administrator failed to provide oversight and direction to staff to ensure the facility complied with certain requirements of Nevada Administrative Code 449.156 to 449.27706, inclusive, and Nevada Revised Statutes Chapter 449. Findings include: Please see Tags Y053, and Y0104. Severity: 2 Scope: 3		compliance identified. We will review our operational protocols to include more detailed steps for supervision and compliance checks. Additionally, we will conduct a complete audit of current practices against the NAC and NRS requirements to identify and correct any further areas of non-compliance. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur (MUST ADDRESS); o Systematic Changes: To ensure the deficient practice does not recur, we will implement a continuous education program for all staff that includes quarterly updates on NAC and NRS requirements and any changes thereto. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur (MUST ADDRESS); o Monitoring Plan: The effectiveness of corrective actions will be monitored through monthly compliance audits, the results of which will be reviewed by the Administrator and the Facility Owner. 4) The title of the person (position)				

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	the facility failed to ensure 1 of 6 employees had an employee file present at the facility (Employee #6). Findings include: On 06/20/23 at 10:10 AM, Employee #3 verbalized there are two caregivers that work on the weekends only. On 06/20/23 at 10:10 AM, Employee #3 explained only five employee files could be located and verbalized the Administrator is working on the missing employee file. Employee #3 confirmed there were no employee files on site for Employee #6. On 06/20/23 at 10:10 AM, Employee #6 was not present in the facility providing care to residents. On 06/20/23 at 10:45 AM, Employee #3 confirmed Employee #6 did not have employee file present and complete at the facility. Severity: 2 Scope: 1		LLC, ensuring it includes all mandatory documentation such as the employment application, background checks, and training certificates. 2. What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur (MUST ADDRESS); Systematic Change: To prevent the recurrence of this matter, we will implement the following systematic changes: - Establishing a Policy on Maintenance of Employee Binders in the group home. (Attachment B). - Periodic Audits: Establishment of a routine schedule for conducting internal audits of employee files to ensure ongoing compliance and identify any discrepancies at an early stage. - Regular Training Sessions: Conduct regular training sessions for all administrative staff on the proper management of employee files. 3. How the corrective action(s) will be monitored to ensure the deficient practice will not recur (MUST ADDRESS);	

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			Monitoring Plan: The effectiveness of the corrective actions and the sustainability of compliance will be ensured through: - Monthly Compliance Reviews: The Administrator and Facility Owner will perform monthly reviews of employee file completeness and accuracy. 4. The title of the person (position) responsible for ensuring the plan of correction is implemented (DO NOT INCLUDE PERSONAL NAMES, JUST USE THE TITLE or POSITION) (MUST ADDRESS); - Administrator and Facility Owner 5. The date the corrective action will be completed (MUST INCLUDE); - The corrective action was done June of 2023, the establishment of a regular audit schedule, will begin on August 8, 2024. 6. You must attach all supporting documents into the system (MUST INCLUDE) - See Attachment B				
0104	Personnel Files - Background Checks -	0104				04/07/202	

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	NAC 449.200 Personnel files. (NRS 449.0302) 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: (f) Evidence of compliance with NRS 449.122 to 449.125, inclusive. Inspector Comments: Based on record review and interview, the facility failed to maintain a personnel record with the State Notification of Clearance letter specific to the facility for the criminal background check of 4 of 6 employees (Employee #1, #4, #5, and #6). Findings include: Employee #1 Employee #1 was hired as a Caregiver on 07/18/23. Employee #1's personnel record included a Notification of Clearance letter, dated, 08/01/22. However, the background check clearance letter was not for this facility. The employee's record lacked documented evidence of a State clearance letter for this facility. On 06/20/23 at 7:00 AM, the facility's NABS account lacked documented evidence of Employee #1 being entered and cleared. Employee #4 Employee #4 was hired as an Administrator on 03/10/20. Employee #4's personnel record included a Notification of Clearance letter, dated, 03/10/21. However, the background check clearance letter was not for this facility. The employee's record lacked documented evidence of a State clearance letter for this facility. On 06/20/23 at 7:00 AM, the facility's NABS account lacked documented evidence of Employee #4 being entered and cleared. Employee #5 Employee #5 was hired as an Owner on 03/31/20. Employee #5's personnel record included a Notification of Clearance letter dated 03/31/20. However, the background check clearance letter was not for this facility. The employee's record lacked documented evidence of a State clearance letter for this facility. On 06/20/23 at 7:00 AM, the facility's NABS account lacked documented evidence of Employee #5 being entered and cleared. Employee #6				1. How you will correct the specific finding(s) stated in the Statement of Deficiencies (MUST ADDRESS); Correction Plan: Immediate Action Taken: For Employees #1, #4, #5, and #6, Background Check and Notification Clearance is already filed, ensuring they are specific to Corinthian Place South LLC. 2. What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur (MUST ADDRESS); Systematic Change: We will update the procedures outlining the steps for conducting background checks through the state's NABS system. This document will be readily accessible to all relevant staff members involved in the hiring process. <i>(Attachment C)</i> 3. How the corrective action(s) will be monitored to ensure the deficient practice will not recur (MUST ADDRESS); Monitoring Plan: Regular Audits: Administrator and Facility Owner will conduct monthly audits of employee files to ensure all required documents, including the appropriate state clearance letters, are present and up to date. Any discrepancies found will be addressed immediately. This process will be reviewed quarterly to assess its effectiveness and make adjustments as needed.		4

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	Employee #6 was hired as a Caregiver. Employee #6's personnel record included a Notification of Clearance letter dated, 06/10/22. However, the background check clearance letter was not for this facility. The employee's record lacked documented evidence of a State clearance letter for this facility. On 06/20/23 at 7:00 AM, the facility's NABS account lacked documented evidence of Employee #6 being entered and cleared. On 06/20/23 at 11:32 AM, the Criminal Background staff confirmed the Employee #6 lacked background check. On 06/20/23 at 10:11AM, the Caregiver confirmed the employee's file lacked documented evidence of the fingerprints being submitted and the required Clearance Letter and Employee #1, #4, #5, and #6 was not cleared in the facility's NABS account. Severity: 2 Scope: 3		4. The title of the person (position) responsible for ensuring the plan of correction is implemented (DO NOT INCLUDE PERSONAL NAMES, JUST USE THE TITLE or POSITION) (MUST ADDRESS); • Administrator and Facility Owner 5. The date the corrective action will be completed (MUST INCLUDE); • The corrective action is done already June of 2023. For the systematic change and monitoring plan, including the establishment of a regular audit schedule, will begin on August 8, 2024. 6. You must attach all supporting documents into the system (MUST INCLUDE) • See Attachment C				