

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/21/2025
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) 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 01/21/2025. This survey 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 Groups beds for the elderly or disabled persons, Category II residents. The facility had requested to add the Mental Illness endorsement to the facility's license. The census at the time of the survey was nine. Nine resident files were reviewed, and six employee files were reviewed. The facility received a grade of D. 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:	ID PREFIX TAG 0000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
0053 SS= D	Administrator's Responsibilities-Complete Rec - NAC 449.194 Responsibilities of administrator. (NRS 449.0302) The administrator of a residential facility shall: 4. Ensure that the records of the facility are complete and accurate. Inspector Comments: Based on personnel record review, document review, and interview, the Administrator failed to ensure the facility maintained complete and accurate records for 1 of 6 employees (Employee #6). Finding include: Employee #6 Employee #6 was hired by the facility as a Caregiver/Medication Technician with an undetermined start date in December 2024. On 01/21/2025 at 1:30 PM, Employee #6 lacked a personnel file at the time of reviewing employee personnel files in the facility during the State survey. During the personnel file review, the Lead Caregiver provided documents from another facility the employee worked at previously. The facility could not provide Employee #6's application, proof of employee's age, start	0053	1. How you will correct the specific finding(s) stated in the Statement of Deficiencies (MUST ADDRESS); The Administrator will ensure that Employee #6's personnel file is completed with all required documents, including the application, proof of age, start date, reference checks, tuberculosis testing and clearance, and the Nevada Revised Statute 449 acknowledgment. These	01/28/2025

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 Name: EUGENE GASATAYA Title: Administrator
REPRESENTATIVE'S SIGNATURE

Date: 02/03/2025

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	date in December 2024, reference checks, tuberculosis testing and clearance, and the Nevada Revised Status 449 acknowledgment. On 01/21/2025 at 2:04 PM, the Lead Caregiver confirmed the missing documented evidence aforementioned for Employee #6 and verbalized the employee had worked at another facility for the same Owner and transferred to this facility. Severity: 2 Scope: 1		documents will be collected and placed in the employee's file immediately. <i>Refer to Attachment A</i> 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur (MUST ADDRESS); A standardized onboarding checklist will be implemented for all new hires to ensure that all required documents are collected before an employee starts work. <i>Refer to Attachment B</i> Additionally, a designated staff member (Owner and/or Lead Caregiver) will verify the completeness of personnel files before the employee begins their duties. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur (MUST ADDRESS); The Administrator and/or Owner will conduct monthly personnel file audits to ensure all employee records	

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			are complete and up to date. Any missing or incomplete files will be addressed immediately. A compliance log will be maintained to track audit results, which will be reviewed during monthly meetings. <i>Refer to Attachment U</i> 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): January 28, 2025	
0065 SS= F	Qualifications of Caregivers-Age-Eng- Training - NAC 449.196 and LCB File No.	0065	1. How you will correct the specific finding	02/15/2025

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	R043-22 Qualifications and training of caregivers. (NRS 449.0302) 1. A caregiver of a residential facility must: (a) Be at least 18 years of age; (b) Be responsible and mature and have the personal qualities which will enable him or her to understand the problems of elderly persons and persons with disabilities; (c) Understand the provisions of NAC 449.156 to 449.27706, inclusive, and sections 2 to 16 inclusive of this regulation and sign a statement that he or she has read those provisions; (d) Demonstrate the ability to read, write, speak and understand the English language; (e) Possess the appropriate knowledge, skills and abilities to meet the needs of the residents of the facility; and (f) Not later than 60 days after commencing employment with the residential facility, receive not less than 4 hours of a combination of tier 1 and tier 2 training related to care for the residents of the facility; and (g) Receive annually not less than 8 hours of training related to providing for the needs of the residents of a residential facility. Such training must include, without limitation, at least 2 hours of tier 2 training. Inspector Comments: R043-22 Sec. 6. "Tier 2 training" means training for employees of a residential facility that includes, without limitation, training in: 1. The psychosocial aspects of dementia; 2. Current science concerning dementia; 3. Signs and symptoms of dementia; and 4. Working with persons who have dementia, including, without limitation: (a) Communication; (b) Providing person-centered care; (c) Assessment of persons with dementia; (d) Planning the provision of care; and (e) Assisting with activities of daily living. Based on record review, document review and interview, the facility failed to ensure 4 of 4 employees working at the facility greater than 60 days received the required elements of Tier 2 training within 60 days of hire and annually thereafter (Employee #2, #3, #4, and #5). Findings include: The following employee lacked documented evidence of Tier 2 training was completed during the annual caregiver - Employee #2 was hired by the facility as the		(s) stated in the Statement of Deficiencies (MUST ADDRESS): The Administrator will ensure that all employees receive the required Tier 2 training as mandated by NAC 449.196 and LCB File No. R043-22. Employees #2, #3, #4, and #5 will complete the required Tier 2 training within 14 days. Documentation of completion will be placed in their personnel files. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur (MUST ADDRESS). - A mandatory training schedule will be implemented to ensure all employees receive the required Tier 2 training within 60 days of hire and annually thereafter. - A training log will be maintained to track employee training dates and ensure compliance <i>Refer to Attachment U.</i> 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur (MUST ADDRESS); - The Administrator or Owner will conduct quarterly audits of employee training records to verify completion of required training. - Any employee who has not completed Tier 2 training within the designated timeframe will be immediately scheduled for the next available session. - Training records will be reviewed during administrative meetings to ensure ongoing compliance. 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);	

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	Owner/Caregiver with a start date of 03/31/2020. - Employee #3 was hired by the facility as the Lead Caregiver/Medication Technician with a start date of 06/30/2023. - Employee #4 was hired by the facility as a Caregiver/Medication Technician with a start date of 06/30/2023. - Employee #5 was hired by the facility as a Caregiver/Medication Technician with a start date of 07/07/2020. On 01/21/2025 at 12:24 PM, the Lead Caregiver confirmed Employee #2, #3, #4, and #5 lacked Tier 2 training as part of the annual caregiver training for 2024. Severity: 2 Scope: 3		Administrator and Facility Owner 5) The date the corrective action will be completed (MUST INCLUDE): February 15, 2025	
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 and interview, the facility failed to maintain an accurate employee schedule, including the scheduled work times and any staffing changes. Findings include: On 01/21/2025 in the morning, review of the January 2025 Employee Schedule revealed the schedule lacked the working times next to the scheduled employee and there was not a documented change on 01/21/2025 for a caregiver on the schedule but not working and a caregiver not on the schedule and working in the facility. The January 2025 Employee Schedule documented employee #2 and #3 were scheduled to work without a posted work time. Employee #2 was not working in the facility. Employee #6 was not on the schedule and was working in the facility. On 01/21/2025 at 1:20 PM, the Lead Caregiver confirmed the January 2025 Employee Schedule did not have the scheduled work times and Employee #2 was not working in the facility on 01/21/2025 and Employee #3 and #6 were working in the facility during the State survey on 01/21/2025. Severity: 1 Scope: 3	0088	1. How you will correct the specific finding (s) stated in the Statement of Deficiencies (MUST ADDRESS); The Owner and/or Lead Caregiver will immediately update the employee schedule to ensure it includes the scheduled work times for each employee. Any changes to the schedule, including shift swaps or absences, will be documented in real-time. The January 2025 Employee Schedule will be corrected to reflect accurate staffing records. <i>Please refer to Attachment C</i> 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur (MUST ADDRESS); - The Owner and Lead Caregiver will review and approve the schedule before posting. - The Lead Caregiver will be responsible for documenting any real-time staffing changes, including shift swaps and replacements at the start each shift as needed. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur (MUST ADDRESS); - The Owner will conduct weekly audits of the posted schedule to ensure all staff names, shifts, and changes are documented correctly. - Compliance will be reviewed during	01/28/2025

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			monthly meetings, and any discrepancies will be immediately corrected. 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): January 28, 2025	
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 tuberculosis (TB) screening was completed in accordance with Nevada Administrative Code 441A.375 for 3 of 6 employees (Employee #3, #5 and #6). Findings include: Employee #3 Employee #3 was hired by the facility as a Caregiver/Medication Technician with a start date of 06/30/2023. Employee #3's personnel file documented a negative X-ray test dated 07/08/2014. Employee #3's personnel file lacked documented evidence of a positive TB test. Employee #3's personnel file documented a TB signs and symptoms questionnaire dated 06/12/2023. Employee #4's personnel file lacked documented evidence of a TB signs and symptoms questionnaire for 2024. Employee #5 Employee #5 was hired by the	0102	1. How you will correct the specific finding (s) stated in the Statement of Deficiencies (MUST ADDRESS); The Administrator will ensure that all required TB screening and documentation are completed for Employees #3, #5, and #6. - Employee #3 will undergo a TB test or provide documented evidence of a positive TB test and updated TB clearance. <i>Please refer to Attachment E</i> - Employee #5 will complete a TB test or screening for 2024 and submit results for personnel file documentation. <i>Please refer to Attachment F</i> - Employee #6 will undergo a TB test or provide documented evidence of a positive TB test and updated TB clearance. <i>Please refer to Attachment G</i> 2) What measures or systematic change(s) will be put into place to ensure the deficient	01/28/2025

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	facility as a Caregiver/Medication Technician with a start date of 07/07/2020. Employee #5's personnel file documented a TB signs and symptoms questionnaire dated 11/14/2023. Employee #5's personnel file documented a TB QuantiFERON lab test dated 01/20/2025. Employee #5's personnel file lacked documented evidence of TB screening or testing for 2024. Employee #6 Employee #6 was hired as a Caregiver/Medication Technician with an undermined start date in December 2024. Employee #6 lacked a personnel file with TB clearance prior to working with residents. On 01/21/2025 at 2:33 PM, the Lead Caregiver confirmed Employee #3 lacked documented evidence of a positive TB test and TB screening in 2024, Employee #5 lacked TB testing or screening in 2024, and Employee #6 lacked a personnel file documenting TB clearance. Severity: 2 Scope: 3		practice does not recur (MUST ADDRESS); - A TB screening checklist will be added to the employee onboarding process to ensure all new hires complete TB clearance before starting work. <i>Please refer to Attachment B</i> - A tracking system (Google Calendar) will be implemented to monitor and remind employees of their annual TB screening requirements. - The Administrator or Owner will verify TB documentation is complete during personnel file audits. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur (MUST ADDRESS); - The Administrator will conduct quarterly audits of personnel files to confirm all employees have current TB screening records. - Any missing TB documentation will be addressed immediately, and employees will not be scheduled to work until compliance is met. 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): January 28, 2025	
0520 SS= F	Supervision and Treatment of Residents - NAC 449.259 and R043-22 Supervision and treatment of residents generally. (NRS 449.0302) 2. A person-centered service	0520	1. How you will correct the specific finding (s) stated in the Statement of Deficiencies (MUST ADDRESS);	01/28/2025

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	plan developed pursuant to this section must include, without limitation: (a) Provisions concerning activities of daily living, medication management, cognitive safety, assistive devices, special needs, social and recreational needs and involvement of ancillary services; (b) Protective supervision as necessary for the resident; (c) The manner in which all caregivers will be informed of the required supervision of the resident; (d) The manner in which the facility will ensure that the resident has the opportunity to attend the religious service of his or her choice and participate in personal and private pastoral counseling; (e) Permission for the resident to rest in his or her room at any time; (f) Permission for the resident to enter or leave the facility at any time if the resident: (1) Is physically and mentally capable of leaving the facility; and (2) Complies with the rules established by the administrator of the facility for leaving the facility; (g) Laundry services for the resident unless the resident elects in writing to make other arrangements; (h) The manner in which the facility will ensure that the resident's clothes are clean, comfortable and presentable; (i) A requirement that the facility must inform the resident or his or her representative of the actions that the resident should take to protect the resident's valuables; (j) A written program of activities for the resident that includes scheduled and unscheduled activities that are suited to his or her interests and capacities; Inspector Comments: Based on record review and interview, the facility failed to ensure a person-centered service plan was developed to address the facility's treatment of residents for 9 of 9 residents reviewed for service plans (Resident #1, #2, #3, #4, #5, #6, #7, #8 and #9). Findings include: The following residents' records lacked documented evidence of a person-centered service plan in their clinical record to address the treatment needs of the residents by the facility's caregiver staff: - Resident #1 was admitted to the facility on 01/31/2023, with diagnoses including hypertension, hyperlipidemia, mobility impairment and bilateral glaucoma. -		The Administrator and Owner will ensure that a person-centered service plan is developed, documented, and implemented for each current resident, including Residents #1 through #8. Each resident's service plan will be individualized and address all required components, including: Individual Assessment, Activities of Daily Living, Goals and Preference, Care and Service Provided, Risk Assessment and Mitigation, Activities and Engagement, Monitoring and Documentation, Family and Resident Involvement, Caregiver Responsibilities, and Review and Updates. <i>Please refer to Attachments H, I, J, K, L, M, N, O</i> 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur (MUST ADDRESS); - Implementation of a Standardized Person-Centered Service Plan Template: A formalized document template will be required for all residents, ensuring compliance with NAC 449.259 and R043-22. - Mandatory Completion Timeline: - New residents: Service plans will be developed within seven (7) days of admission. - Existing residents: Service plans will be reviewed and updated annually or whenever there is a significant change in condition. - Staff Training: - Lead Caregivers will be instructed on documenting resident needs and ensuring that all components are addressed on the Person-Centered-Care Plan. - The Owner will be responsible for reviewing all	

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	Resident #2 was admitted to the facility on 11/30/2024, with diagnoses including advanced dementia, severe cognitive impairment, traumatic brain injury, hyperlipidemia, and neurogenic bladder - Resident #3 was admitted to the facility on 12/11/2024, with diagnoses including atherosclerosis, cervical disc degeneration, and hypertension. - Resident #4 was admitted to the facility on 01/11/2025, with a diagnosis of senile degeneration of brain. - Resident #5 was admitted to the facility on 12/09/2023, with diagnoses including Alzheimer's disease, osteoporosis, hypertension, and anxiety. - Resident #6 was admitted to the facility on 06/22/2024, with diagnoses including arthritis, dementia, cerebral vascular accident with left hemiplegia, and hypertension. - Resident #7 was admitted to the facility on 10/22/2024, with diagnoses including dementia and bilateral hearing loss. - Resident #8 was admitted to the facility on 05/01/2022, with diagnoses including dementia, hypertension, edema, and benign prostatic hyperplasia. - Resident #9 was admitted to the facility on 05/08/2021, with diagnoses including gastro-esophageal reflux disease, depression, anxiety, breast cancer, osteoporosis, and hypertension. On 01/21/2025 at 2:40 PM, the Lead Caregiver confirmed the facility had not created current person-centered service plans for the residents currently residing in the facility affecting 9 of 9 residents. Severity: 2 Scope: 3		new admissions to ensure a completed Person-Centered Care plan is in place. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur (MUST ADDRESS); - Monthly Audits: The Owner and Lead Caregiver will conduct monthly audits of all resident records to verify that: - Each resident has a completed and up-to-date care plan. - Any changes in the resident's condition are reflected in the updated care plan. - The Progress Note will be reviewed weekly by the Administrator or Owner to ensure timely updates and compliance. - Care plans will be discussed during administrative meetings, and any deficiencies will be corrected immediately. 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): January 28, 2025	

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0645 SS= C	Disclosure of Information Concerning Rates - NAC 449.2704 and R043-22 Disclosure of information concerning rates and payment for services. (NRS 449.0302) 1. The administrator of a residential facility shall, upon the request of any person, make the following information available in writing: (a) The basic rate for the services provided by the facility; (b) The schedule for payment; (c) The services included in the basic rate; (d) The charges for optional services which are not included in the basic rate; and (e) The residential facility ' s policy on refunds of amounts paid but not used. 2. Upon admitting a resident to a residential facility, changing the services provided for in a person-centered service plan or changing the cost of those services or upon request, the administrator of a residential facility shall provide a written description of the services included in the person-centered service plan of a resident and the cost of those services to the person paying for those services or his or her representative. NRS 449A.280 Required provisions of contract for delivery of services. Sec. 9. A contract between a resident and a residential facility for groups for the delivery of services to the resident must: 1. Be entitled "Service Delivery Contract for Residential Facility for Groups"; 2. Be printed in at least 12 point type; and 3. Include, without limitation, the following information in the body of the contract or in a supporting document or attachment: (a) The name, physical address and mailing address, if different, of the residential facility for groups; (b) The name and mailing address of every person, partnership, association or corporation which establishes, conducts, manages or operates the residential facility for groups; (c) The name and address of at least one person who is authorized to accept service on behalf of the parties described in paragraph (b); (d) A telephone number or the address of the Internet website of: (1) The Division that the resident or a representative of the resident may use to verify the status of the license of the residential facility for groups;	0645	1. How you will correct the specific finding (s) stated in the Statement of Deficiencies (MUST ADDRESS); Facility is in full compliance with regulations, as all Admission Agreements include the monthly rate for basic services and optional services and have always been securely stored in a separate locked cabinet, accessible only to the owner. The versions in resident binders had the fees covered for privacy reasons, which led to the misunderstanding during the inspection. To ensure clarity during future inspections, a duplicate copy of the Admission Agreement (including rates) will be available upon request, while maintaining resident confidentiality. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur (MUST ADDRESS); Basic service rates will now be posted in a visible area within the facility for easy reference by residents, families, and surveyors <i>(Please Refer to Attachment V)</i>. The Addendum A form has been revised to clearly document optional service rates, ensuring it meets regulatory requirements. <i>(Please Refer to Attachment W)</i> 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur (MUST ADDRESS); The posted rate sheet will be updated as needed, and the Owner or Administrator will review forms periodically to ensure they	02/15/2025

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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	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 (2) Each licensing board or other regulatory body that has issued a license to a provider of health care or other person required to be licensed who provides services to residents at the residential facility for groups that the resident or a representative of the resident may use to verify the status of the license of the provider of health care or other person; (e) The duration of the contract; (f) The manner in which the contract may be modified, amended or terminated; (g) The base rate to be paid by the resident and a description of the services to be provided as part of the base rate; (h) A fee schedule outlining the cost of any additional services; (i) Any additional fee to be paid by the resident pursuant to the fee schedule and a description of any additional services to be provided as part of that fee, either directly by the residential facility for groups or by a third-party provider of services under contract with the facility; (j) A statement affirming the freedom of the resident to receive services from a provider of services with whom the residential facility for groups does not have a contractual arrangement, which may also disclaim liability on the part of the residential facility for groups for any such services; (k) The procedures and requirements for billing and payment under the contract; (l) A statement detailing the criteria and procedures for admission, management of risk and termination of residency; (m) The obligations of the resident in order to maintain residency and receive services, including, without limitation, compliance with the annual physical examination and assessment required by NRS 449.1845; (n) A description of the process of the residential facility for groups for resolving the complaints of residents and contact information for the Aging and Disability Services Division and the Division of Public and Behavioral Health of the Department of Health and Human Services; (o) The name and mailing address of any representative of the resident, if applicable; and (p) Contact information for: (1) The State Long-Term Care Ombudsman appointed pursuant to NRS 427A.125; (2) The Nevada Disability Advocacy and Law Center, or its		remain aligned with the Admission Agreement. 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): February 15, 2025	

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	successor organization; or (3) Other resources for legal aid or mental health assistance, as appropriate. Inspector Comments: Based on interview, record review, and document review, the facility failed to ensure a contract outlined the rate for basic services and the rate for optional services was properly completed for 9 of 9 residents residing in the facility. Findings include: On 01/21/2025, in the morning, a review of all residents' records for the nine residents residing in the facility at the time of the annual State survey, revealed all of the residents' Admission Agreements lacked documented evidence of the monthly rate for each resident for basic services and the rate for optional services per Addendum A to the Admission Agreement. On 01/21/2025 at 9:34 AM, the Lead Caregiver confirmed all nine residents' Admission Agreements lacked the rate for basic services and lacked the rate for optional services in Addendum A. Severity: 2 Scope: 1			
0936 SS= D	Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he or she permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including, without limitation: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. Inspector Comments: Based on document review, clinical record review and interview, the facility failed to ensure 1 of 9 residents met the requirements concerning tuberculosis (TB) testing in accordance with Nevada Administrative Code (NAC) 441A.375 (Resident #3). Findings include: Resident ## Resident #3 was admitted to the facility on 12/11/2024, with diagnoses	0936	1. How you will correct the specific finding (s) stated in the Statement of Deficiencies (MUST ADDRESS); The Administrator will ensure that Resident #3's clinical record is updated to include the necessary tuberculosis (TB) testing documentation in compliance with NAC 441A.375. Resident #3 will undergo a TB test (QuantiFERON) on January 27, 2025 to confirm TB status. <i>Refer to Attachment P</i> 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur (MUST ADDRESS); Pre-Admission Screening: All new residents must provide documentation of TB testing before admission, including proof of a negative TB test or evidence of a positive test with appropriate follow-	01/28/2025

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	including atherosclerosis, cervical disc degeneration, and hypertension. Resident #3's clinical record documented a negative chest X-ray dated 10/01/2024 and a TB signs and symptoms questionnaire dated 12/11/2024. Resident #3's clinical record lacked documented evidence of a positive TB test. On 01/21/2025 at 2:43 PM, the Lead Caregiver confirmed Resident #3's clinical record lacked evidence of a positive TB test. Severity: 2 Scope: 1		up (chest X-ray and annual symptom screening). - Resident File Checklist: A Resident Medical File Checklist will be implemented to ensure that all required health records, including TB documentation, are present upon admission and remain current. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur (MUST ADDRESS); - The Administrator or Owner will conduct quarterly compliance reviews to ensure that TB documentation is updated for all residents. - A Resident File Compliance Log will be maintained, tracking each resident's TB testing history and due dates for required screenings. 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): January 28, 2025	

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1010	Care for Persons with Mental Illnesses - NAC 449.2764 Residential facility which offers or provides care for persons with mental illnesses: Application for endorsement; training for employees. (NRS 449.0302) 1. A residential facility which offers or provides care and protective supervision for a resident with mental illness must obtain an endorsement on its license authorizing it to operate as a residential facility for persons with mental illnesses. The Division may deny an application for an endorsement or suspend or revoke an existing endorsement based upon the grounds set forth in NAC 449.191 or 449.1915. Inspector Comments: Based on personnel file review, document review and interview, the facility Administrator failed to obtain eight hours of required training to complete the application approval for the mental illness endorsement. The Administrator's trainings of record were obtained in March 2017 and the application lacked current trainings. The approval of the application is pending evidence of current required trainings.	1010	1. How you will correct the specific finding (s) stated in the Statement of Deficiencies (MUST ADDRESS); The Administrator will complete the required eight (8) hours of training specific to the care and protective supervision of persons with mental illnesses to fulfill the application requirements for the endorsement. The Administrator will enroll in and complete a state-approved training program that satisfies the requirements outlined in NAC 449.2764. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur (MUST ADDRESS); Training Monitoring and Scheduling: ◦ The Administrator and Owner will maintain a training log to track mandatory training requirements and expiration dates. ◦ A renewal reminder system (Google Calendar) will be implemented to ensure that all required training is completed and updated before any applications or renewals. ◦ 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur (MUST ADDRESS); • The Administrator and Owner will	02/25/2025

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			conduct quarterly reviews of training records to verify compliance with training requirements for endorsements. This will be included on the Existing Training Compliance Log to monitor the completion and expiration dates of all required trainings. 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): February 25, 2025	
1600 SS= C	Preferred Name/Pronoun P& P - NAC 449.011943 Policies concerning preferred names and pronouns; adaptation of records to reflect gender identities or expressions; method to obtain medically relevant information from patients or residents. (NRS 449.0302, 449.104) 1. A 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) To the extent practicable and available within the systems in use at the facility: (1)Adapt electronic	1600	1. How you will correct the specific finding (s) stated in the Statement of Deficiencies (MUST ADDRESS); The Administrator and Owner will ensure that the facility will revise Admission Record/ Face Sheet in compliance with NAC 449.011943 to: Address each resident by their preferred name and pronoun and in accordance with	02/15/2025

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	records and any paper records the facility uses to reflect the preferred name, pronoun and gender identity or expression of a patient or resident; and (2) Integrate information concerning gender identity or expression into electronic systems for maintaining health records. 2. If a patient or resident chooses to provide the following information, the records adapted pursuant to subparagraph (1) of paragraph (b) of subsection 1 must to the extent required by subsection 1, 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. Inspector Comments: Based on observation, clinical record review and interview, the facility failed to ensure there were policies developed and resident records were in compliance to reflect a resident's preferred name, pronoun, gender identity or expression, and sexual orientation for 9 of 9 residents in the facility (Resident #1, #2, #3, #4, #5, #6, #7, #8, and #9). Findings include: The following residents' records lacked the inclusion of a resident's choice to provide the resident's preferred name, pronoun, gender identity or expression, and sexual orientation: - Resident #1 was admitted to the facility on 01/31/2023, with diagnoses including hypertension, hyperlipidemia, mobility impairment and bilateral glaucoma. -		their gender identity or expression. 2. Adapt resident records to include the option for documenting: - Preferred name and pronoun. - Gender identity or expression. - Sexual orientation (if the resident chooses to disclose this information). - Gender assigned at birth. The facility will also update the admission records for all nine (9) residents to provide them with the opportunity to supply the required information. Each resident (or their legal representative) will be interviewed to confirm their preferences and ensure the information is accurately documented in their records. <i>Please refer to Attachment Q</i> 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur (MUST ADDRESS); 1. Development and Implementation: - A Preferred Name, Pronoun, and Gender Identity will be integrated to the existing forms to outline the facility's commitment to respecting residents' preferences and ensuring compliance with NAC 449.011943. 2. Resident Record Updates: <i>Please refer to Attachment R</i> - A Resident Information Form will be modified and provided to each current resident (or their legal representative) to collect information on their preferred name, pronoun, gender identity, sexual orientation, and any other relevant information they choose to disclose. - This form will be included as	

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	Resident #2 was admitted to the facility on 11/30/2024, with diagnoses including advanced dementia, severe cognitive impairment, traumatic brain injury, hyperlipidemia, and neurogenic bladder - Resident #3 was admitted to the facility on 12/11/2024, with diagnoses including atherosclerosis, cervical disc degeneration, and hypertension. - Resident #4 was admitted to the facility on 01/11/2025, with a diagnosis of senile degeneration of brain. - Resident #5 was admitted to the facility on 12/09/2023, with diagnoses including Alzheimer's disease, osteoporosis, hypertension, and anxiety. - Resident #6 was admitted to the facility on 06/22/2024, with diagnoses including arthritis, dementia, cerebral vascular accident with left hemiplegia, and hypertension. - Resident #7 was admitted to the facility on 10/22/2024, with diagnoses including dementia and bilateral hearing loss. - Resident #8 was admitted to the facility on 05/01/2022, with diagnoses including dementia, hypertension, edema, and benign prostatic hyperplasia. - Resident #9 was admitted to the facility on 05/08/2021, with diagnoses including gastro-esophageal reflux disease, depression, anxiety, breast cancer, osteoporosis, and hypertension. On 01/21/2025 at 2:40PAM, the Lead Caregiver confirmed there were no changes to residents' clinical records in compliance with the regulation. Severity: 1 Scope: 3		part of the admission process for all new residents. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur (MUST ADDRESS); Quarterly Record Audits: • The Administrator and Lead Caregiver will conduct quarterly audits of all resident records to ensure that preferred name, pronoun, and gender identity information is accurately documented and updated as needed. • Missing or outdated information will be corrected immediately. • Refresher training for staff will be provided annually or as needed using third party Cultural Competency Training program. 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): February 15, 2025	

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1700 SS= D	Annual Assessment of History of Each Resident - NRS 449.1845 Administrator of residential facility for groups to conduct annual assessment of history of each resident and cause provider of health care to conduct certain examinations and assessments; placement based on assessment. 1. The administrator of a residential facility for groups shall: (a) Annually cause a qualified provider of health care to conduct a physical examination of each resident of the facility; (b) Annually conduct an assessment of the history of each resident of the facility, which must include, without limitation, an assessment of the condition and daily activities of the resident during the immediately preceding year; and (c) Cause a qualified provider of health care to conduct an assessment of the condition and needs of a resident of the facility to determine whether the resident meets the criteria prescribed in paragraph (a) of subsection 2: (1) Upon admission of the resident to the facility; and (2) If a physical examination, assessment of the history of the resident or the observations of the administrator or staff of the facility, the family of the resident or another person who has a relationship with the resident indicate that: (I) The resident may meet those criteria; or (II) The condition of the resident has significantly changed. 2. If, as a result of an assessment conducted pursuant to paragraph (c) of subsection 1, the provider of health care determines that the resident: (a) Suffers from dementia to an extent that the resident may be a danger to himself or herself or others if the resident is not placed in a secure unit or a facility that assigns not less than one staff member for every six residents, any residential facility for groups in which the resident is placed must meet the requirements prescribed by the Board pursuant to subsection 2 of NRS 449.0302 for the licensing and operation of residential facilities for groups which provide care to persons with Alzheimer's disease or other severe dementia. (b) Does not suffer from dementia as described in paragraph (a), the	1700	1. How you will correct the specific finding (s) stated in the Statement of Deficiencies (MUST ADDRESS); The Administrator will ensure that Resident #6's Physician Placement Determination and associated documentation are brought into compliance. The delay in completing the determination for Resident #6 (15 days after admission) will be addressed by: 1. Reconfirming Resident #6's placement appropriateness with a provider of health care. 2. Updating Resident #6's clinical record to reflect this confirmation. <i>Please see Attachment S</i> 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur (MUST ADDRESS); 1. Pre-Admission Procedure Update: It will be implemented requiring the Physician Placement Determination to be completed within 7 days of admission. Residents will not be considered fully admitted until the Physician Placement Determination is completed. 2. Coordination with Health Care Providers: The facility will establish agreements with providers of health care to ensure they can complete placement determinations within the required timeframe. 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur (MUST ADDRESS); 1. Admission File Audits: The Administrator will review all admission files to ensure placement determinations are completed within	01/31/2025

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	resident may be placed in any residential facility for groups. 3. As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031. (Added to NRS by 2019, 2594) Inspector Comments: Based on interview and clinical record review, the facility failed to ensure a standard placement determination was completed timely by a provider upon admission for 1 of 9 residents (Resident #6). Findings include: Resident #6 Resident #6 was admitted to the facility on 06/22/2024, with diagnoses including arthritis, dementia, cerebral vascular accident with left hemiplegia, and hypertension. Resident #6's clinical record documented a Physician Placement Determination dated 07/07/2024, 15 days after the resident's admission to the facility. On 01/21/2025 at 2:40 PM, the Lead Caregiver confirmed Resident #6's Physician Placement Determination for the facility was completed late by the provider. Severity: 2 Scope: 1		7 days of admission. Any delays will be documented, and corrective action will be taken immediately. 2. Ongoing Compliance Tracking: The facility will maintain a Placement Determination Log, tracking the date of admission and the completion of the placement determination for each resident. <i>Please refer to Attachment T</i> 3. Annual Review Compliance: A Resident Annual Assessment Log will be implemented to track due dates for annual physical exams and assessments. This will ensure that all residents have their medical and placement needs reassessed annually. <i>Please refer to Attachment T</i> 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): January 31, 2025	
1840 SS= E	UNL Caregiver Training - R063-21 Sec. 4 1. An unlicensed caregiver who provides care to residents, patients or clients at a facility described in section 3 of this regulation shall annually complete evidence-based training provided by a nationally recognized organization concerning the control of	1840	1. How you will correct the specific finding (s) stated in the Statement of Deficiencies (MUST ADDRESS); The Administrator will ensure that Employees #3 and #4 complete the	01/31/2025

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NAME OF PROVIDER OR SUPPLIER CORINTHIAN PLACE SOUTH LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5855 LONE HORSE DR, RENO, NEVADA ,89502		
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	infectious diseases. The training must include, without limitation, instruction concerning: (a) Hand hygiene; (b) The use of personal protective equipment, including, without limitation, masks, respirators, eye protection, gowns and gloves; (c) Environmental cleaning and disinfection; (d) The goals of infection control; (e) A review of how pathogens, including, without limitation, viruses, spread; and (f) The use of source control to prevent pathogens from spreading. 2. Each unlicensed caregiver who completes the training required by subsection 1 must provide proof of completion of that training to the administrator or other person in charge of the facility in which the unlicensed caregiver provides care. Inspector Comments: Based on interview and personnel record review, the facility failed to ensure infection control (IC) training, for unlicensed caregivers, was completed for 2 of 5 employees (Employee #3 and #4). Findings include: Employee #3 Employee #3 was hired by the facility as the Lead Caregiver/Medication Technician with a start date of 06/30/2023. Employee #3's personnel file lacked documented evidence the employee completed all of the Infection Control required training elements. Employee #4 Employee #4 was hired by the facility as a Caregiver/Medication Technician with a start date of 06/30/2023. Employee #4's personnel file lacked documented evidence the employee completed all of the Infection Control required training elements. On 01/21/2025 at 11:55 AM, the Lead Caregiver confirmed Employee #3 and #4 lacked the required Infection Control training. Severity: 2 Scope: 2		required Infection Control (IC) training as mandated by R063-21 Sec. 4. <i>Please refer to Attachment Y, Z</i> - Both employees will be enrolled in an evidence-based infection control training program provided by a nationally recognized organization. - Proof of training completion, including a certificate, will be added to their personnel files. 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur (MUST ADDRESS); - Mandatory Annual IC Training: Training will be scheduled with Annually through CDC's Train.org. - Training Compliance Tracking: The facility will maintain an Employee Important Training Logs for all employees, tracking completion dates and due dates for annual training. <i>Please refer to attachment U</i> - Updated Onboarding Procedures: The onboarding checklist for new hires will be updated to include verification of completion of infection control training within 30 days of hire <i>Please refer to attachment B.</i> 3) How the corrective action(s) will be monitored to ensure the deficient practice will not recur (MUST ADDRESS); - Quarterly Training Audits: The Administrator or Owner will conduct quarterly audits of employee files to confirm compliance with infection	

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/21/2025
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			control training requirements. 2. Compliance Meetings: Compliance with infection control training will be reviewed during monthly meetings. 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): January 31, 2025	