

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10619	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/14/2022
NAME OF PROVIDER OR SUPPLIER AWAY FROM HOME ADULT CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1040 VIA DELL BACIO DRIVE, HENDERSON, NEVADA ,89052		
(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 the State Licensure Initial survey conducted at your facility on 12/14/22, in accordance with Nevada Administrative Code, Chapter 449, Residential Facilities for Groups. The facility has requested licensure for ten Residential Facility for Group beds for elderly or disabled persons, and/or persons with Alzheimer's disease, and/or persons with chronic illness, Category II. The census at the time of the survey was 0. Two employee files and one mock resident file were reviewed. 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. There were no deficiencies identified. No further action is necessary at this time. Please retain this Statement for your records.			

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: _____ Title: _____ Date: _____
REPRESENTATIVE'S SIGNATURE