

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10710	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/25/2023
NAME OF PROVIDER OR SUPPLIER KINGS ROW RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 1254 SAINT ALBERTS DR, RENO, NEVADA ,89503		
(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 an off-site change of ownership, State Licensure survey initiated on 04/17/23 and finalized on 04/25/23. This State Licensure Survey was conducted in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility requested 10 Residential Facility for Group beds for elderly and disabled persons, and/or persons with mental illness, and/or persons with chronic illness, and/or individuals with intellectual disabilities; three Category I and seven Category II residents. Facility policies and protocols were reviewed. The application was approved for 10 Residential Facility for Group beds for elderly and disabled persons, and/or persons with mental illness, and/or persons with chronic illness, and/or individuals with intellectual disabilities; three Category I and seven Category II residents. 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. No regulatory deficiencies were identified. No further action necessary. Please retain a copy 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