

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 03/31/2022
NAME OF PROVIDER OR SUPPLIER EAGLE VALLEY CARE CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 1807 E LONG STREET, CARSON CITY, NEVADA ,89701	
(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 03/31/22. This State Investigation was conducted by the Division of Public and Behavioral Health in accordance with NAC 449, Residential Facility for Groups. The census at the time of investigation was 29. The sample size was five. There was one complaint investigated. Complaint #NV00065999 with the following allegation could not be substantiated. Allegation #1: A resident with a diagnosis of impaired cognition suffered a physical injury after a sexual encounter with another resident in the facility could not be substantiated due to lack of evidence. The investigation into the allegations included: Observations of residents and a brief tour of the facility. Interviews were conducted with two residents, the Administrator, and Supervisor. Review of five resident files including the resident of concern. Document review included Ultimate User Agreement, Activities of Daily Living (ADLs), Admission Records, Physician Plan of Care, History and Physicals, Standard Physician Assessments, Placement Determination forms, the facility's Grievance policy and a policy for Resident Rights. 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.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER Name:
REPRESENTATIVE'S SIGNATURE

Title:

Date:

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.