

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1959	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2026
NAME OF PROVIDER OR SUPPLIER MASON VALLEY RESIDENCE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 705 SOUTH STREET, YERINGTON, NEVADA ,89447		
(X4) ID PREFIX TAG RFG 0000- No Deficiencies	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) The Statement of Deficiencies was generated as a result of a state licensure survey conducted in your facility, in accordance with Nevada administrative code, chapter 449, and Nevada revised statutes chapter 449- Residential Facility for Groups (RFG), medical facilities and other related entities. The findings and conclusions of any investigation by the Division of Health Care Purchasing and Compliance shall not be construed as prohibiting any criminal civil investigation, actions or other claims for reliefs that may be available to any party under applicable federal, state or local law. The RFG was found to be in substantial compliance. No regulatory deficiencies were identified. No further action is necessary. Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation completed in your facility on 01/23/2026. The census at the time of the survey was 40. The sample size was six. There were two complaints investigated. Complaint 12761, deficient practice was not identified. Complaint 12853, deficient practice was not identified. The investigation of the complaints included: Observation of residents in rooms, residents in common areas, grooming and physical appearance of residents, a meal observation, staff-to-resident interactions, resident-to-resident interactions, and a tour of the facility. Interviews were conducted with residents,	ID PREFIX TAG RFG 0000- No Deficiencies	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

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:
REPRESENTATIVE'S SIGNATURE

Title:

Date:

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	Caregivers, Medication Technicians, an Activities/Transportation employee, the Business Office Manager, and the Executive Director. Clinical Record Review of six records, which included the residents of concern. Document Review included facility policies and procedures, facility schedules, and personnel record review for five employees to include abuse, neglect, and dementia training, performance reviews and any disciplinary action taken by the facility.			