

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/18/2017	
NAME OF PROVIDER OR SUPPLIER HAPPY ADULT CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 1905 QUAIL POINT COURT, LAS VEGAS, NEVADA ,89117			
(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		
0000	Initial Comments - Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation conducted at your agency on 5/14/18, in accordance with Nevada Revised Statutes, Chapter 449, Personal Care Agencies. The census at the time of the survey was 6. The sample size was 5 Complaint #NV00049925 with the following allegations could not be substantiated. Allegation #1: The Facility failed to connect a resident with necessary medical treatment Allegation #2: The Facility neglected a resident's care. The investigation for the allegations included: Review of the resident's records, physician records, emails between the resident's guardians and the facility. Interviews with the facility owner, residents's guardians, residents, and caregivers 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. Please retain a copy of this notice for your records.	0000					

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.