Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2807	A. BUILDING _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUNAMAR HOME HEALTH INC	**7907 MOUNTAIN MAN WAY, LAS VEGAS, NEVADA ,89113**

(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: The surveyor arrived at the Residential facility for groups address and observed the facility was in operation. The facility license expired on 12/31/24 and a renewal application was not submitted and paid for. The surveyor informed the facility representative they are operating as an unlicensed facility and must immediately apply for a new license through the Aithent Licensing System (CLICs). All license applications are made online, and renewal notices were sent to the email address listed in the facility's online profile in the database prior to expiration. Failure to submit an initial application immediately may result in an unlicensed investigation of your facility and pursuant to NRS 449.210, you may be subject to a civil penalty of not more than $10,000 for the first offense or not less than $10,000 or more than $25,000 for a second or subsequent offense. The findings and conclusions of any investigation by the Division of Public and Behavioral Health (DPBH) shall not be construed as prohibiting any criminal or civil investigations, actions, or other local claims for relief that may be available to any party under applicable federal, state, or local laws.	0000		

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 REPRESENTATIVE'S SIGNATURE Name: Title: Date: