

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 04/04/2024	
NAME OF PROVIDER OR SUPPLIER PARK PLACE				STREET ADDRESS, CITY, STATE, ZIP CODE 2305 IVES COURT, RENO, NEVADA ,89503			
(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 State Licensure complaint investigation conducted at your facility on 04/04/24. This State Licensure survey was conducted by the Division of Public and Behavioral Health in accordance with NAC 449, Residential Facility for Groups. The facility was licensed for 60 Residential Facility for Group beds for elderly or disabled persons, and/or persons with mental illness and provides assisted living services, Category II residents. The census at the time of the survey was 39. Three resident files and two employee files were reviewed. One complaint was investigated. Complaint #NV00070520 could not be substantiated due to lack of evidence. Allegation #1: The facility failed to follow their financial policy. Allegation #2: The facility did not refund a deposit fee when a resident was not able to move into the facility due to change of condition. The investigation into the allegations included: Observations of residents in common areas, staff and resident interactions, and business office operations. Interviews with one resident, the Executive Director, and the Wellness Director. Review of the facility's Residence and Care Agreement, Application and Deposit policy, Termination policy, and Refund policy. 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 investigation, 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.	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.