

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 339	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/08/2024	
NAME OF PROVIDER OR SUPPLIER PRIME CARE FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 4920 RONAN DRIVE, LAS VEGAS, NEVADA ,89110		
(X4) ID PREFIX TAG 0000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure survey completed at your facility on 10/08/2024, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility was licensed for seven Residential Facility for Group beds for persons with mental illness, Category I residents. The census at the time of the survey was seven. Seven resident files and two employee files were reviewed. The facility received a grade of A. 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.	ID PREFIX TAG 0000	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: Title: Date:
REPRESENTATIVE'S SIGNATURE