

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

PRINTED: 6/15/2026
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/03/2022
NAME OF PROVIDER OR SUPPLIER MORNINGSTAR OF SPARKS			STREET ADDRESS, CITY, STATE, ZIP CODE 2360 WINGFIELD HILLS DR, SPARKS, NEVADA ,89436	
(X4) ID PREFIX TAG 0000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG 0000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as the result of a State Licensure complaint investigation conducted at your facility on 10/03/22, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility was licensed for 112 Residential Facility for Group beds, with 80 beds for assisted living services for elderly and disabled persons and/or persons with chronic illnesses and 32 beds for persons with Alzheimer's disease, Category II. The census at the time of the survey was 69. The sample size was zero. There was one complaint investigated. Complaint #NV00067019 with the allegation the facility does not isolate COVID-19 positive residents could not be substantiated due to lack of evidence. The investigation into the allegation included: Observations of staff and residents in the main entrance/atrium area, hallways, and the Assisted Living dining room. Observations of visitors entering the facility being screened for temperature and signs and symptoms of COVID-19. Interviews with the Administrator and Wellness Director. Review of the facility's Infection Control and Prevention policy. 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. No regulatory deficiencies were identified. No further action is necessary. Please retain a copy for your records.			

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.