

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 7210	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/22/2017
NAME OF PROVIDER OR SUPPLIER ORMSBY HEIGHTS RESIDENTIAL CARE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 210 SOUTH ORMSBY BLVD, CARSON CITY, NEVADA ,89703		
(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 a result of an annual State Licensure survey conducted in your facility on 02/22/17. This State Licensure survey was conducted by the authority of NRS 449.0307, Powers of the Division of Public and Behavioral Health. The facility is licensed for ten Residential Facility for Group beds for elderly and disabled persons and/or persons with mental illnesses Category I five residents and Category II five residents. The census at the time of the survey was four. Four resident files were reviewed and four 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. No deficiencies were noted. Please keep a copy for your records.			

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