

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 7437	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2019
NAME OF PROVIDER OR SUPPLIER ADULT COMFORT AND CARE HOME, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2105 CARROLL ST, LAS VEGAS, NEVADA ,89030		
(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 a annual State Licensure at your facility on 01/23/19, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups The facility is licensed for ten Residential Facility for Group beds for elderly and disabled persons and/or persons with chronic illness and/or persons with mental illness and/or persons with mental retardation. Ten Category II residents. The census at the time of the survey was ten. Ten resident files were reviewed and five employee files were reviewed. The facility received a grade of A. The findings and conclusions of any investigation by the Health Division 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			

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