

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

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER: |                                                                                                                          | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                          |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>09/16/2024</b> |  |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADULT COMFORT AND CARE HOME, LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                       |                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br><b>2105 CARROLL ST, LAS VEGAS, NEVADA ,89030</b> |                            |                                                        |  |
| (X4)<br>ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY<br>OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |                                                                                               | (X5)<br>COMPLETION<br>DATE |                                                        |  |
| 0000                                                                        | <p>Initial Comments</p> <p>Inspector Comments: This Statement of Deficiencies was generated as a result of an annual state licensure survey an complaint investigation conducted at your facility on 19/16/24, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facilities for Groups. The facility is licensed for 10 Residential Facility for Group beds for elderly and disabled persons and/or persons with mental illnesses, and/or persons with chronic illnesses and/or persons with intellectual disabilities, Category II residents. The census at the time of the survey was nine. Nine resident files and four employee files were reviewed. The facility received a grade of A. There was one complaint investigated. Unsubstantiated: 1. Complaint #NV00071724 could not be substantiated. No regulatory deficiencies could be identified The investigation of the complaint included: Observation of grooming and physical appearance of residents, and a tour of the facility. Interviews were conducted with residents, and the Administrator. Record Review of nine resident records, which included the resident of concern. 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. There were no regulatory deficiencies identified. No further action necessary. Please retain a copy for your records.</p> | 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.