

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 01/02/2020	
NAME OF PROVIDER OR SUPPLIER BAILEYS GROUP HOME INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1998 ARCANUE AVENUE, RENO, NEVADA ,89503			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation initiated at your facility on 01/02/20. This State investigation was conducted by the Division of Public and Behavioral Health in accordance with NAC 449, Residential Facility for Groups. The facility is licensed for six Residential Facility for Group beds for elderly and disabled persons and/or persons with mental illnesses, five Category II and one Category I residents. The census at the time of the survey was four. There was one complaint investigated. Complaint #NV00059741 with the following allegation could not be substantiated. Allegation #1: No method of professional accountability for families who approach owners with concerns. The investigation into the allegation included: Observations of facility staff, residents and a tour of the facility. Interviews were conducted with the Administrator/Owner and the Caregiver/Owner. 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. No regulatory deficiencies were identified. No further action is necessary. Please retain a copy of this report for your records.	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.