

Division of Public and Behavioral Health

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>8317</b>                              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                     | (X3) DATE SURVEY<br>COMPLETED<br><br><b>04/16/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ADULT COMFORT AND CARE HOME 2</b>    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br><b>10315 QUEENSBURY AVENUE, LAS VEGAS, NEVADA ,89135</b> |                                                                                                                          |                                                        |
| (X4)<br>ID<br>PREFIX<br>TAG<br><br><b>RFG<br/>0000- No<br/>Deficiencies</b> | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY<br>OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG<br><br><b>RFG<br/>0000- No<br/>Deficiencies</b>                                   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE                             |
|                                                                             | <p>The Statement of Deficiencies was generated as a result of a state licensure survey conducted in your facility, in accordance with Nevada administrative code, chapter 449, and Nevada revised statutes chapter 449- Residential Facility for Groups (RFG), medical facilities and other related entities.</p> <p>The findings and conclusions of any investigation by the Division of Health Care Purchasing and Compliance shall not be construed as prohibiting any criminal civil investigation, actions or other claims for reliefs that may be available to any party under applicable federal, state or local law.</p> <p>The RFG was found to be in substantial compliance. No regulatory deficiencies were identified. No further action is necessary.</p> <p>Inspector Comments: This Statement of Deficiencies was generated as a result of an annual survey initiated at your facility on 04/16/26.</p> <p>The facility is licensed for ten Residential Facility for Group beds for elderly and disabled persons and/or individuals with intellectual disabilities, and/or mental illness, Category II residents.</p> <p>The census at the time of the survey was nine.</p> <p>Nine resident files and five employee files were reviewed.</p> <p>The facility received a grade of A.</p> |                                                                                                       |                                                                                                                          |                                                        |

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