Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9063	A. BUILDING _____ B. WING _____	05/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIMI'S CARE HOME	3055 S PIONEER WAY, LAS VEGAS, NEVADA ,89117

(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 initial survey, initiated at your facility on May 29, 2018. This State Licensure Complaint Survey was conducted by the authority of NRS 449.0307, Powers of the Division of Public and Behavioral Health and in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is requesting to be licensed for ten Residential Facility for Group beds for elderly and disabled persons, and/or persons with chronic illness, and/or persons with Alzheimer's disease, Category II residents. The census at the time of the survey was zero. One sample resident file was reviewed and one employee file was reviewed. 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.	0000		

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 REPRESENTATIVE'S SIGNATURE Name: Title: Date: