

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 9415	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/08/2021
NAME OF PROVIDER OR SUPPLIER GOLDEN HEART GROUP HOME CARE I		STREET ADDRESS, CITY, STATE, ZIP CODE 3413 ALPAND LANE, SPARKS, NEVADA ,89434		
(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 State Licensure bed increase survey conducted in your facility on 12/08/21. This State Licensure survey was conducted by the Division of Public and Behavioral Health in accordance with NAC 449, Residential Facility for Groups. The facility is licensed for seven residential Facility for Group (RFG) beds for elderly and disabled persons, and/or persons with mental illness, and/or persons with chronic illness, and/or persons with intellectual disabilities, Category II residents. The facility requested licensure for 10 RFG beds for elderly and disabled persons, with endorsements for persons with mental illnesses and/or persons with chronic illness, and/or persons with intellectual disabilities, Category II residents. This application was approved. The facility received a grade of A. 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. No regulatory deficiencies were identified. No further action is necessary. Please retain a copy of this report for your records.			

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