

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 04/18/2023	
NAME OF PROVIDER OR SUPPLIER PEACE OF MIND, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 4354 E HARMON AVE, LAS VEGAS, NEVADA ,89121			
(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 completed at your facility on 04/18/23, in accordance with Nevada Administrative Code (NAC) Chapter 449, Homes for Individual Residential Care. The census at the time of the survey was ten. The facility received a grade of A. The sample size was six. Six resident files were reviewed. One complaint was investigated. Unsubstantiated: Complaint #NV00068059 could not be substantiated. The investigation of the complaint included: Observation of resident hygiene, positioning of call bells, caregivers providing care to residents and the ability of residents to turn in bed. Interviews were conducted with a Caregiver, the Owner, a Registered Nurse and four residents. Record review of six 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 investigations, 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. Maintain a copy 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.