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
	10740	A. BUILDING _____ B. WING _____	09/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY FRIENDLY CARE HOME	**3784 EDISON AVENUE, 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 an initial State Licensure and infection control survey conducted at your facility on 09/06/22, in accordance with Nevada Administrative Code (NAC), Chapter 449. The census at the time of the survey was zero. One sample resident file and one employee file was reviewed. The facility requested licensure for 10 Residential Facility for Groups beds for elderly and disabled persons and/or persons with Chronic Illness, Category II residents. During the initial onsite visit, it was discovered a window did not meet the size measurement requirements for ambient light. As a result, the facility will be approved for licensure for 8 Residential Facility for Groups beds for elderly and disabled persons and/or persons with Chronic Illness, Category II residents. The facility was provided guidance on having an Infection Control Plan. 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. No further action is required. Please retain a copy for your records.	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: