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
	10951	A. BUILDING _____ B. WING _____	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLIMBING ROSE CARE HOME	**3848 CLIMBING ROSE STREET, LAS VEGAS, NEVADA ,89147**

(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 State Licensure Address Verification Survey conducted at your Residential Facility for Groups on 03/07/2024, in accordance with Nevada Administrative Code, Chapter 449. The surveyor arrived at the Residential Facility for Groups address and observed the facility was in operation. The surveyor informed the facility representative they are operating as an unlicensed facility and must immediately renew their license through the Aithent Licensing System (CLICs). All license renewals are made online and renewal notices are sent to the email address listed in the facility's online profile in the database. Failure to submit a renewal application immediately may result in an unlicensed investigation of your facility and pursuant to NRS 449.210, you may be subject to a civil penalty of not more than $10,000 for the first offense or not less than $10,000 or more than $25,000 for a second or subsequent offense. The findings and conclusions of any investigation by the Division of Public and Behavioral Health (DPBH) shall not be construed as prohibiting any criminal or civil investigations, actions, or other local 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: