

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 11251	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/27/2025
--	---	--	--

NAME OF PROVIDER OR SUPPLIER VALAGE SENIOR LIVING AT CARSON VALLEY	STREET ADDRESS, CITY, STATE, ZIP CODE 973 IRONWOOD DRIVE, MINDEN, NEVADA ,89423
---	--

(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	<p>Initial Comments</p> <p>Inspector Comments: This Statement of Deficiencies was generated as a result of an initial State Licensure survey conducted in your facility on 05/27/2025, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility had applied for one hundred sixteen (116) residential facility for groups beds which provides assisted living services for elderly or disabled persons and/or persons with Alzheimer's disease, seventy Category II non-Alzheimer's residents and forty-six Category II Alzheimer's residents. The license is granted for one hundred sixteen (116) residential facility for groups beds which provides assisted living services for elderly or disabled persons and/or persons with Alzheimer's disease, seventy Category II non-Alzheimer's residents and forty-six Category II Alzheimer's residents.. The census at the time of the survey was zero. One mock resident record was reviewed and seven employee personnel file were 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. No regulatory deficiencies were identified. No further action necessary. Please retain a copy for your records.</p>	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: _____