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
	1196	A. BUILDING _____ B. WING _____	04/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF RENO	445 WEST HOLCOMB LANE, RENO, NEVADA ,89511

(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 the result of a State Licensure Survey completed in conjunction with a Federal Recertification survey, at your facility from April 08, 2019 through April 11, 2019, in accordance with Nevada Administrative Code (NAC) Chapter 449, Skilled Nursing Facilities. The census was 98. 20 Employee records were reviewed The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions, or other claims from relief that may be available to any party under applicable federal, state, or local laws. No regulatory deficiencies were identified. 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: