

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>158</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/27/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>DUNCAN MANOR GROUP HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE  <b>6165 DUNCAN DRIVE, LAS VEGAS, NEVADA ,89108</b>		
(X4) ID PREFIX TAG  <b>0000</b>	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG  <b>0000</b>	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Initial Comments</p> <p>Inspector Comments: This Statement of Deficiencies was generated as a result of a State Licensure wellness check Survey conducted at your residential facility for groups, in accordance with Nevada Administrative Code, Chapter 449. 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 claims for relief that may be available to any party under applicable federal, state, or local laws. The surveyor arrived to the residential facility for groups located at 6165 Duncan Dr. Las Vegas, NV 89108 and informed the facility representative they must immediately renew their license. Failing to renew their license could result in a civil penalty of \$10,000.00 if the six resident are still in the facility after 01/31/19.</p>			

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 Name: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_  
REPRESENTATIVE'S SIGNATURE