

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2274	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/08/2020
NAME OF PROVIDER OR SUPPLIER SACHELE SENIOR GUEST HOME 2		STREET ADDRESS, CITY, STATE, ZIP CODE 3397 EL CAMINO REAL, LAS VEGAS, NEVADA ,89121		
(X4) ID PREFIX TAG 0000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG 0000	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 survey conducted in your facility on 01/08/20, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facilities for Groups. The facility is licensed for six Residential Facility for Group beds for elderly and disabled persons, with endorsements for Alzheimer's disease, six Category II residents. The facility has applied for a three bed increase and was approved to add three group beds which provide services for elderly and disabled persons and/or persons with Alzheimer's disease, for a total of nine Category II beds. 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 investigation, 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 necessary. Please retain a copy for your records.</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