



Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>240</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/21/2022</b>	
NAME OF PROVIDER OR SUPPLIER  <b>JOHNSON GROUP CARE #1</b>		STREET ADDRESS, CITY, STATE, ZIP CODE  <b>1895 CARVILLE DR, RENO, NEVADA ,89512</b>		
(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
			<p>Measures have been put in place to ensure that this deficit does not occur: residential facility will ensure that residents requiring room and board, meals, assistance, and limited supervision does not exceed the specified number on the facility's license for a total census of six. The residential facility will continue to monitor residents needs; review with service coordinators changes in care plan, and ensure that a detailed plan is created for changes in placement that includes dates for transfer or discharge for that</p> <p>resident.</p> <p>#3To monitor performance the residential facility will document facilities census, communicate with service coordinators census numbers (full/vacancy), track and monitor detailed plan for transfers and discharge. This will be achieved and sustained as the residential facility will not accept residents in excess to the number of six residents specified on the license issued to the owner of the</p> <p>facility.</p> <p>#4 The administrator (Employee #1) is responsible for ensuring the plan of correction is implemented.</p> <p>#5 Resident is no longer residing at the residential facility as of 3/29/22. Documentation was provided to Health Facilities Inspector.</p>	