DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**03/09/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT CARE GROUP HOME	**639 K STREET, SPARKS, NEVADA ,89431**

(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 a result of a complaint investigation conducted at your facility on 03/09/22, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility was licensed for five Residential Facility for Group beds for elderly and disabled persons, Category II residents. The census at the time of the survey was five. The sample size was five. There was one complaint investigated. Complaint #NV00065220 with the following allegations could not be substantiated. Allegation #1 Resident was not receiving podiatry care. Allegation #2 Resident was being social isolated. The investigation into the allegation included: Observation of facility staff, residents and a tour of the facility. Interviews were conducted with the Caregiver and four residents including the resident of concern. Reviewed five resident files, activities calendar, Administrator and Caregiver notes, and appointment calendar of the resident of concern. 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. There were no regulatory deficiencies identified. Please retain a copy for your files.	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: Title: Date:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.