

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>5679</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/03/2020</b>	
NAME OF PROVIDER OR SUPPLIER  <b>V N SENIOR CARE INC AT WINERY ROAD</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3281 WINERY RD, PAHRUMP, NEVADA ,89048</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
0000	<p>Initial Comments</p> <p>Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State licensure survey conducted in your facility on 03/03/20, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facilities for Groups. The facility is licensed for ten Residential Facility for Group beds for elderly and disabled persons, with an endorsement for Alzheimer's disease, ten Category II residents. The census at the time of the survey was eight. Eight resident files were reviewed and five employee files were reviewed. The facility received a grade of A. 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>	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 Name: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_  
REPRESENTATIVE'S SIGNATURE