

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 7414	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/06/2017
NAME OF PROVIDER OR SUPPLIER SIERRA MANOR CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 327 RIVER FLOW DRIVE, RENO, NEVADA ,89523		
(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
	Initial Comments - Inspector Comments: This Statement of Deficiencies was generated as a result of Bed Increase survey conducted in your facility on 04/06/17. This State Licensure survey was conducted by the authority of NRS 449.0307, Powers of the Division of Public and Behavioral Health. The facility is currently licensed for a total of five Residential Facility for Group beds for elderly and disabled persons, Category II. The facility is requesting licensure for three additional Residential Facility for Group beds for elderly and disabled persons, Category I residents. 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. Regulatory deficiencies identified at the time of survey were corrected. No further deficiencies were identified. Please keep a copy of this statement for your records. No further action is required.			

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