

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 A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/12/2017	
NAME OF PROVIDER OR SUPPLIER ARBORS MEMORY CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 2121 EAST PRATER WAY, SPARKS, NEVADA ,89434			
(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 on your facility on 10/12/17. This complaint investigation was conducted by the authority of NRS 449.0307, Powers of the Division of Public and Behavioral Health. The census at the time of the survey was 56. The sample size was 5. There was one complaint investigated. Complaint #NV00050164 with one allegation could not be substantiated. Allegation #1 - Resident/Patient/Client Rights; No process to locate Clothes/Resident personal items. The investigation into the allegations included: Observation of the laundry room and process to keep residents clothing returned, and a tour of the facility. Interviews were conducted with the laundry staff, housekeeping, caregivers and the facility Designee. Review of five resident medical records including the resident of concern. Review of the facility resident master list which is used to monitor the clothing for each resident. 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.	0000					

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

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.