

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 9280	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/09/2018
NAME OF PROVIDER OR SUPPLIER AVONDALE CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 6215 EAST OWENS AVENUE, LAS VEGAS, NEVADA, 89110		
(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 Bed Increase survey conducted in your facility on 07/09/18, in accordance with Nevada Administrative Code (NAC) 449, Residential Facilities for Groups. The facility is currently licensed for a total of nine Residential Facility for Group beds for elderly and disabled persons and/or persons with chronic illness and/or mental illness, Category II residents. The facility is requesting licensure for one additional Residential Facility for Group beds for elderly and disabled persons and/or persons with chronic illness and/or mental illness, Category II 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. No regulatory deficiencies were identified. No further action is necessary. Please retain a copy of this report for your records.	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 REPRESENTATIVE'S SIGNATURE	Name:	Title:	Date:
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