Division of Public and Behavioral Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 9832 | A. BUILDING _____ B. WING _____ | 03/11/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **GOLDEN ROSE HOME** | **8055 OPAL STATION DRIVE, RENO, NEVADA ,89506** |

| (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<br><br>Inspector Comments: This Statement of Deficiencies was generated as a result of a follow up survey to the Initial State Licensure survey conducted in your facility on 03/11/21. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The census at the beginning of the survey was one. The facility is currently licensed as a Home for Individual Residential Care with two beds. The facility is requesting to be licensed for nine Residential Facility for Group beds for elderly and disabled persons, six Category I and three Category II residents. The State Licensure for a Residential Facility for Groups application was not approved based on regulatory deficiencies. A third onsite survey was conducted where previously identified deficiencies were corrected. 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 deficiencies identified. The facility is in substantial compliance with the regulations. Please retain a copy 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: