

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS5410ADC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/10/2008
NAME OF PROVIDER OR SUPPLIER SERENITY ADULT DAY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 7550 W ALEXANDER RD LAS VEGAS, NV 89129		
(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) COMPLETE DATE
U 000	<p>INITIAL COMMENTS</p> <p>This Statement of Deficiencies was generated as a result of the initial State Licensure survey conducted at your facility on September 10, 2008. This initial survey was conducted by authority of NAC 449, Facilities For Care Of Adults During The Day, adopted by the State Board of Health on June 23, 1986.</p> <p>The facility will be licensed to accommodate 70 adults for care during the day.</p> <p>There were no deficiencies identified.</p>	U 000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

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