Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	NVS88AGZ		11/06/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL HAVEN	1913 COLLINS AVENUE LAS VEGAS, NV 89106

(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
Y 000	Initial Comments Surveyor: 28380 The findings and conclusions of any investigation by the Health Division 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. This Statement of Deficiencies was generated as a result of an attempted annual State Licensure survey conducted in your facility on 11/04/09 through 11/06/09. There was no one present on the first two attempts at the survey. On the final early morning attempt on 11/06/09 a house sitter was contacted. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is not currently operating as a group care facility. A house sitter and her dog are taking care of the property. The facility does not have any residents residing at the facility and the facility does not plan to admit any residents until the second or third month of 2010. The facility is licensed for six Residential Facility for Group beds which provide care to persons with Alzheimer's disease, Category II residents. An examination of the exterior found the property to be well maintained. The rear of the facility was inaccessible due to the watch dog. Furniture was visible through the front door and window with no disruption of the interior apparent. Please contact the Bureau of Healthcare Quality & Compliance at 775-687-4475 regarding the status and intent of the operation of your facility.	Y 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

Bureau of Health Care Quality and Compliance

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Y 000	Continued From page 1 If you are anticipating operating as a licensed facility, an annual survey is mandatory in order to maintain your licensure.	Y 000		

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