Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVN312AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED C 02/02/2011
NAME OF PROVIDER OR SUPPLIER MOUNTAIN SPRINGS SENIOR CARE COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 2907 N MOUNTAIN STREET CARSON CITY, NV 89703		

(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 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 complaint investigation conducted between 12/30/10 and 1/24/11. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for 30 Residential Facility for Group beds for elderly and disabled persons, Category II residents. One resident file was reviewed and no employee files were reviewed. Complaint #NV00027260 - The allegation regarding quality of resident care was not substantiated through document review, clinical record review and interviews with family members and facility staff. Interviews were conducted with the resident's son and the resident's daughter, facility administrator, facility caregiver and resident care coordinator. An extensive review of hospital records, physician records, nursing agency records and the facility's files was conducted. Resident #1 was 85 years old. The resident experienced a decline in health and overall functioning following admission to the facility. During this same period of time the resident began seeing a new physician and medication changes were ordered, including replacing insulin injections with oral medication. Interviews and	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

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Y 000	Continued From page 1 record review did not provide evidence that the facility provided inadequate care to the resident. No further action is necessary. Please retain a copy for your records.	Y 000		

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