

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS43ADC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/31/2011
NAME OF PROVIDER OR SUPPLIER THE SALVATION ARMY CORP		STREET ADDRESS, CITY, STATE, ZIP CODE 830 EAST LAKE MEAD DRIVE HENDERSON, NV 89015		
(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 State Licensure survey conducted at your facility from 5/24/11 through 5/31/11.</p> <p>The survey was conducted using Nevada Administrative Code (NAC) 449, Facilities For Care Of Adults During The Day, regulations adopted by the Nevada State Board of Health on June 23, 1986.</p> <p>The facility was licensed for 49 total day care clients. The census at the time of the survey was 41. Fifteen client files were reviewed and eight employee files were reviewed.</p> <p>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.</p> <p>The following regulatory deficiencies were 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