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
	10513	A. BUILDING _____ B. WING _____	10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN MANOR SERENITY	465 SYSONBY CT, RENO, NEVADA ,89521

(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 Inspector Comments: This Statement of Deficiencies was generated as a result of an offsite State Licensure initial survey follow-up conducted on 10/28/21. This survey was conducted by the Division of Public and Behavioral Health in accordance with NAC 449, Residential Facility for Groups. The facility applied for two Category I and five Category II beds for the elderly and disabled. Based on review of an accurate Certificate of Compliance, the facility is approved for one Category I and five Category II residential beds for the elderly and disabled. 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. No regulatory deficiencies were identified. No further action is necessary. Please retain a copy of this report 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: