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
	2852	A. BUILDING ______ B. WING ______	**12/17/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY SERVICES AGENCY CARSON CITY EARLY HEAD START	**200 EAST WINNIE LANE SUITE 288-298, CARSON CITY, NEVADA ,89706**

(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
OOOO	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 the on-site State licensure survey conducted at your facility. There were no regulatory deficiencies identified at the time of the survey. Inspector Comments: This statement of deficiencies was generated as a result of an annual inspection conducted at your facility on 12.17.25. The facility is licensed for 54 as a child care center. The census at the time of inspection were 17 children. 10 child files and 17 staff files were reviewed.? General reminders to submit your renewal application/documents/trainings prior to 1.31.26. Please submit your renewal application prior to 12.31.25 to avoid a late fee.	OOOO		

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: