

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>4007</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/03/2026</b>	
NAME OF PROVIDER OR SUPPLIER  <b>KASSIDY PLACE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE  <b>4600 SNYDER AVENUE, CARSON CITY, NEVADA ,89701</b>		
(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	<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>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.</p> <p>Inspector Comments: This statement of deficiencies was generated as a result of a semi annual inspection conducted at your facility on 2.03.26 The facility is licensed for 40 as a child care center. The census at the time of inspection were 19 children. 0 staff files and 0 child files were reviewed at the time of inspection, files will be reviewed at the annual inspection.</p>	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: \_\_\_\_\_