DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**01/18/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE LAS VEGAS	**3025 E RUSSELL ROAD, LAS VEGAS, NEVADA ,89120**

(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 a complaint investigation completed in your facility from 12/23/20 through 01/18/20, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups The census at the time of the survey was 72. The sample size was one. One complaint was investigated. Complaint # NV00062462 with three allegations was substantiated without deficiencies. Allegation #1: Resident to Resident abuse was substantiated without deficiencies. The following allegations could not be substantiated: Allegation #2: Resident neglect was unsubstantiated based on review of incident reports and interviews with one resident, Resident Care Coordinator, and Certified Nursing Assistant. Allegation #3: A resident was not protected from another abusive resident was unsubstantiated based on review of incident reports and interviews with the Administrator and Resident Care Coordinator who reported the resident and/or the resident's roommates were moved to different rooms after incidents occurred. The investigation into the allegations included: Observations of the facility environment, interactions among residents, and residents' bedrooms/apartments. Review of incident reports and resident files. Interviews with resident of concern, facility Administrator and Resident Care Coordinator 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 investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. No regulatory deficiencies were cited. No further action necessary. Please retain a copy for your records.	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: Title: Date:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.