

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 A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/27/2024
NAME OF PROVIDER OR SUPPLIER BROOKDALE LAS VEGAS			STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Initial Comments</p> <p>Inspector Comments: This Statement of Deficiencies was generated as a result of a Facility Reported Incident (FRI) completed in your facility on 02/27/24, in accordance with Nevada Administrative Code, Chapter 449, Requirements for Residential Facilities for Groups. The census at the time of the survey was 58. The sample was two residents and seven employees. Verified with no deficiencies: 1. FRI #9349 was verified. No regulatory deficiencies could be identified. The investigation in to the allegations included: -Interviews were conducted with the Administrator and the Wellness Director. -Clinical record review of two residents, including the resident of concern and Incident Reporting. -Document review of staffing schedules, first aid and cardiopulmonary resuscitation (CPR) for seven employees, and Resident's Personal Rights. 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. There were no regulatory deficiencies identified. No action is necessary. Retain this Statement for your records.</p>	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.