

## Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  NVS2726AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  11/25/2014
NAME OF PROVIDER OR SUPPLIER  CARMELA HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE  5500 CLEARY CT LAS VEGAS, NV 89108		
(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) COMPLETE DATE
Y 000	<p>Initial Comments</p> <p>This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 11/25/14. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Division of Public and Behavioral Health.</p> <p>The facility is licensed for six Residential Facility for Group beds for elderly or disabled persons and/or persons with mental illness Category II residents. The census at the time of the survey was six. Six resident files were reviewed and four employee files were reviewed.</p> <p>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.</p> <p>The facility received a grade of A.</p> <p>There were no regulatory deficiencies identified at this time. Please retain a copy for your records.</p>	Y 000		

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

TITLE

(X6) DATE