

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4959	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/27/2016
NAME OF PROVIDER OR SUPPLIER GARDEN BREEZE ALZHEIMER VILLA		STREET ADDRESS, CITY, STATE, ZIP CODE 950 GARDEN BREEZE WAY, LAS VEGAS, Nevada ,89123		
(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 an annual State Licensure survey conducted in your facility on 7/27/16. This State Licensure survey was conducted by the authority of NRS 449.0307, Powers of the Division of Public and Behavioral Health. The facility is licensed for eight Residential Facility for Group beds for elderly and disabled person and/or persons with Alzheimer's disease. The census at the time of the survey was seven. Seven resident files were reviewed and four employee files were reviewed. 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. The facility received a grade of A. There were no deficiencies identified. The facility is in substantial compliance with the regulations.	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:
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