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 _____	**11/22/2022**

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 the State Licensure Complaint Investigation survey conducted at your facility on 11/22/22, in accordance with Nevada Administrative Code Chapter 449, Residential Facilities for Groups. The facility is licensed for 105 Residential Facility for Group beds for elderly or disabled persons with an endorsement for Assisted Living, Chronic Illness, and Alzheimer's disease. The census at the time of the survey was 51. Three resident records were reviewed. The facility received a grade of A. One complaint was investigated: Complaint #NV00067067 with eight allegations was unsubstantiated: Allegation #1: A resident had 21 falls over a period of almost three years, and no fall precautions were put into place was unsubstantiated based on lack of evidence the resident sustained 21 falls, record review of the resident of concern, and interviews with the Administrator and the Resident Care Coordinator, who reported various fall prevention measures such as frequent cues and reminders, regular checks, and consultation with the physician were implemented. Allegation #2: A resident went six days without food and had only a minimal amount of water to drink was unsubstantiated based on review of the Hospice Plan of Care and interviews with the Resident Care Coordinator and the Administrator, who reported the resident of concern was provided with palliative, end of life care per resident and family authorization which was overseen by the Hospice Registered Nurse. Interview with the Hospice Registered Nurse revealed the resident's care at end of life was appropriate, and the resident was not dehydrated or neglected. There was no documented evidence the resident was dehydrated or had nutritional problems. Allegation #3: Staff were unable to provide adequate care to residents due to staffing	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.

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	shortages. The staffing was inadequate and dangerous was unsubstantiated based on interviews with the Administrator, the Resident Care Coordinator, and the Human Resource Manager, six residents, and two family members. Observation of resident care and assistance by staff of residents on 11/22/22 and tour of the facility revealed appropriate care, there were no foul odors, residents were well-groomed, and residents' rooms, linens, and clothing were clean. Interviews with six residents and two family members, who indicated care and assistance by staff was appropriate, staff was helpful, and they did not have any concerns or problems. Allegation #4: The facility did not provide the proper level of care for a resident was unsubstantiated based on interviews with the Resident Care Coordinator, the Administrator, and the Hospice Registered Nurse, who reported the resident of concern was provided with appropriate, end of life palliative care per the Hospice Plan of Care. Allegation #5: Call bells were not answered timely. The emergency call system was not efficient was unsubstantiated based on testing of the call bell system on 11/22/22 at 2:00 PM with a 2 minute response time, and interviews with six residents and two family members, who reported no delays in call bell response. Review of call bell logs for the week of 09/21/22 and on 11/22/22 revealed timely call bell responses for the resident of concern and for other residents. Allegation #6: Residents were left wet or soiled for an extended time was unsubstantiated based on observation of staff assisting residents with care, ten resident rooms, and tour of the facility on 11/22/22, which revealed there were no foul odors and residents were well groomed. Residents' clothing and linens were clean, and there was no evidence of lack of incontinence care. Allegation #7: The Assistant Director and staff would not address a family member's concerns was unsubstantiated based on review of the resident of concern's record			

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	(authorization to release information to the legal Power of Attorney in accordance with HIPAA (Health Insurance Portability and Accountability Act), review of the Administrator's grievance logs and Regional Director's documentation. Interviews were conducted with six residents and two family members, who reported no problems with the staff's response to complaints. Document review included the facility's Grievance Policy and Grievance Logs. Allegation #8: A resident's room was disgusting with filthy carpet and the trash can had overflowing substances was unsubstantiated based on tour of the facility on 11/22/22, and observation of ten residents' rooms, including the resident of concern's room. There were no foul odors, floors were clean, there was no evidence of trash overflowing. Interviews with six residents and two family members revealed they were very happy with the cleanliness of the facility. Interviews with Caregivers, the Maintenance Director, and the Regional Maintenance Technician revealed the facility had a thorough cleaning schedule. Interview with the Hospice Registered Nurse, who reported the resident of concern's room was always kept clean, no overflowing trash, and the carpet was clean with no odors or stains. The investigation into the allegations included: -Review of three resident records, including the resident of concern; -Interviews with the Administrator, Resident Care Coordinator, three Caregivers, the Human Resource Manager, six residents, two family members, and a Hospice Registered Nurse; -Observations on 11/22/22; and -Document review of Call Bell Logs, Grievance Logs, Level of Care Policy, Grievance Procedure Policy, Housekeeping Cleaning Logs, Housekeeping Schedules, and Staffing Schedules. The findings and conclusions of any investigation by the Division of Public and B behavioral Health shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for			

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	relief that may be available to any party under applicable federal, state, or local laws. There were no regulatory deficiencies identified. No further action is necessary. Please retain a copy of this Statement for your records.			