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 _____	**07/30/2025**

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 an annual State Licensure survey completed at your facility on 07/30/25 in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 105 Residential Facility for Group beds for elderly and disabled persons and/or persons with Alzheimer's disease and/or persons with mental illness, Category I and Category II residents. The census at the time of the survey was sixty-nine. Seventeen resident files and ten employee files were reviewed. There were four complaints investigated. Substantiated without deficient Practice: 1. Complaint #NV00074446 was substantiated with no deficient practice. Unsubstantiated: 2. Complaint #NV00074429 was unsubstantiated. No regulatory deficiencies could be identified. 3. Complaint #NV00074226 was unsubstantiated. No regulatory deficiencies could be identified. 4. Complaint #NV00074789 was unsubstantiated. No regulatory deficiencies could be identified. The investigation of the Complaints included: Observation of residents in the facility, staff providing care to residents, staff treatment of residents, facility fall precautions, oxygen tanks, and call bell light response. Interviews were conducted with residents, a Lead Caregiver, Caregivers, Medication Technicians, Wellness Director, and the Administrator. Record Review of five records, which included the residents of concern. Document review of oxygen tank delivery receipt, resident agreement, and the Medication Administration Record. The facility received a grade of B. 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	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: CHRIS MIRANDO Title: ADMINISTRATOR Date: 08/21/2025

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.

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 _____	**07/30/2025**

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
	to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:			
0102 SS= D	Personnel File - TB Screening - NAC 449.200 Personnel files. 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (d) The health certificates required pursuant to chapter 441A of NAC for the employee; Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 10 sampled employees received a chest X-ray when required (Employee #3). Findings include: Employee #3 (E3) E3 was hired on 06/23/22 as a Caregiver. E3's file recorded a Quantiferon Gold tuberculin (TB) test on 03/06/25 with an indeterminate result. E3's file contained a requistion for a follow-up chest X-ray, but E3's file lacked documented evidence of the test results from a follow-up chest X-ray to rule out active TB. On 07/30/25 in the afternoon, the Business Office Manager acknowledged E3 had not received a chest X-ray to rule out active TB, and they should have had this on file. Severity: 2 Scope: 1	0102	E3 was sent and received an updated negative chest x-ray on 8/4/2025 and result was placed in associate file. Executive Director or designee will audit 4 associate files a week for 8 weeks to verify ongoing compliance.	08/04/2025

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 _____	**07/30/2025**

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
0255 SS= E	Permits-Comply with NAC 446 on Food Service - NAC 449.217 Kitchens; storage of food; adequate supplies of food; permits; inspections. (NRS 449.0302) 6. A residential facility with more than 10 residents shall: (a) Comply with the standards prescribed in chapter 446 of NAC; and (b) Obtain the necessary permits from the Division. Inspector Comments: Based on observation on 07/30/2025, the facility failed to ensure the kitchen and supportive dining services complied with the standards of NAC 446. Findings include: 1. Critical Violations: a. In a reach-in refrigerator, a carton of buttermilk was expired 07/17/25 and two containers of cottage cheese were expired 07/20/25; one container of cottage cheese had an open date of 07/25/25. 2. Major Violations: a. The dumpster enclosure was heavily soiled with grease and seepage underneath the grease rendering receptacle and there was a large puddle of grease on the left side of the dumpster enclosure. 3. Equipment and Maintenance Violations: a. The janitor closet was not organized and had cleaning supplies stacked on top of milk crates. Severity: 2 Scope: 2	0255	1. Expired items were disposed of at time of compliance visit on 7/30/2025. 2. Dumpster enclosure scheduled to be cleaned by 8/31/2025. 3. Janitor closet was reorganized on 7/31/2025. Dining Service manager/Designee will follow routine schedule to monitor for food items expiration dates. Maintenance Director/designee will routinely monitor cleaning schedules. Executive Director or designee will review cleaning schedule monthly x 3 months to verify ongoing compliance.	07/30/2025

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 _____	**07/30/2025**

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
0991 SS= E	Alzheimer 's Care Standards for Safety - NAC 449.2756 and R043-22 Residential facility which provides care to persons with Alzheimer ' s disease: Standards for safety; personnel required; training for employees. (NRS 449.0302) 1. The administrator of a residential facility which provides care to persons with Alzheimer ' s disease or other forms of dementia who meet the criteria prescribed in paragraph (a) of subsection 2 of NRS 449.1845 shall ensure that: (b) Operational alarms, buzzers, horns or other technology for notifying staff when a door is opened are installed on all doors that may be used to exit the facility. Inspector Comments: Based on observation and interview, the facility failed to ensure the memory care exit doors had an audible alarm. Findings include: On 07/30/25, in the morning, 3 of 3 exit doors, one of which led to the memory care courtyard, did not have a functional audible alarm when the doors were opened. On 07/30/25, in the morning, the Health and Wellness Director (HWD) acknowledged the door, which led into the backyard, did not have an audible alarm because it was shut off. The Maintenance Director and HWD were present when the door findings were made. Severity: 2 Scope: 2	0991	Exit door audible alarms were fixed on 7/30/2025. Staff was re-trained on audible alarms at all exit doors on 7/30/2025 by Maintenance Director. Alarm systems functionality is monitored regularly by maintenance director and executive director. Executive Director or designee will test exit alarms once a week for 8 weeks to verify ongoing compliance.	07/30/2025

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 _____	**07/30/2025**

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
1011 SS= D	Care for Persons with Mental Illnesses - NAC 449.2764 Residential facility which offers or provides care for persons with mental illnesses: Application for endorsement; training for employees. (NRS 449.0302) 2. A person who provides care for a resident of a residential facility for persons with mental illnesses shall, within 60 days after becoming employed at the facility, attend not less than 8 hours of training concerning care for residents who are suffering from mental illnesses. Inspector Comments: Based on record review and interview, the facility failed to ensure 8 hours of mental illness training was completed within 60 days of hire for 1 of 10 sampled employees (Employee #8). Findings include: Employee #8 (E8) E8 was hired on 02/26/25 as a Medication Technician. E8's file documented completion of 0.5 hour of mental illness training, plus two mental illness training courses in progess, but not yet completed. E8's file lacked documented evidence of 8 hours of mental illness training completed within 60 days of hire. On 07/30/25 in the afternoon, the Business Office Manager verbalized E8 was still working on their mental illness training requirement, and had not completed 8 hours of training within 60 days as required. Severity: 2 Scope: 1	1011	E8 mental illness training was completed on 7/31/2025 of 8.5 hours total. Executive Director or designee will ensure compliance of 8 hours of mental illness training for associates within 60 days. Executive Director or designee will audit 4 associate files a week for 8 weeks to verify ongoing compliance.	07/31/2025
1540 SS= D	Cultural Competency Training - R004-24 Cultural competency training for agent or employee who provides care to patient or resident. (NRS 449.0302, 449.103) 1. Except as otherwise provided in NRS 449.103, as amended by section 1 of Assembly Bill No. 267, chapter 202, Statutes of Nevada 2023, at page 1176, a facility shall provide cultural competency training through an approved course or program to an agent or employee described in subsection 2 of NRS 449.103, as amended by section 1 of Assembly Bill No. 267, chapter 202, Statutes of Nevada 2023, at page 1176: (a) Within 90 days after	1540	E8 cultural competency was completed on 8/1/2025. Executive Director or designee will ensure associates complete cultural competency within 90 days of hire going forward. Executive Director or designee will audit 4 associate files a week for 8 weeks to verify ongoing compliance.	08/01/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**07/30/2025**

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
	contracting with or hiring the agent or employee; (b) At least biennially thereafter. Such biennial training must consist of at least 2 hours of instruction each biennium. 2. The facility may provide the training required by subsection 1 over several instructional periods or during a single instructional period so long as the agent or employee: (a) Completes the hours of cultural competency training required by subsection 1 and the entire contents of the course or program; and (b) Receives a certificate of completion on or before the date on which subsection 1 requires the agent or employee to complete the cultural competency training. 3. Except as otherwise provided in subsection 4, the facility shall keep documentation in the personnel file of an agent or employee of the facility or a record of an agent or employee in the relevant electronic system of the facility proof of the completion of the cultural competency training required pursuant to NRS 449.103, as amended by section 1 of Assembly Bill No. 267, chapter 202, Statutes of Nevada 2023, at page 1176. 4. If an agent or employee of a facility is exempt from the requirement to complete cultural competency training pursuant to subsection 3 of NRS 449.103, as amended by section 1 of Assembly Bill No. 267, chapter 202, Statutes of Nevada 2023, at page 1176, the facility shall maintain proof in the personnel file of the agent or employee or a record of the agent or employee in the relevant electronic system of the facility that the agent or employee holds a valid professional license, registration or certificate, as applicable, for which the continuing education described in subsection 3 of NRS 449.103, as amended by section 1 of Assembly Bill No. 267, chapter 202, Statutes of Nevada 2023, at page 1176, is required for renewal. Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 10 sampled employees were in			

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 _____	**07/30/2025**

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
	compliance with Nevada Revised Statutes (NRS) 449.103 regarding cultural competency training. Findings include: Employee #8 (E8) E8 was hired on 02/26/25 as a medication technician. E8's file contained a certificate for a cultural competency course not approved by the Bureau. E8's file lacked documented evidence of approved cultural competency training within 90 days of hire. On 07/30/25 in the afternoon, the Business Office Manager acknowledged the cultural competency course completed by E8 was not an approved course, and E8 should have taken an approved course. Severity: 2 Scope: 1			