

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 06/06/2024	
NAME OF PROVIDER OR SUPPLIER PRESTIGE ASSISTED LIVING AT HENDERSON				STREET ADDRESS, CITY, STATE, ZIP CODE 1050 E LAKE MEAD PARKWAY, HENDERSON, NEVADA ,89015			
(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 a complaint investigation initiated on 05/29/24 completed on 06/06/24, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The census at the time of survey was 35. The sample size was five. The facility received a grade of A. There were two complaints investigated. Substantiated without deficient Practice: 1. Complaint #NV00071015 was substantiated with no deficient practice. 2. Complaint #NV00071382 was substantiated with no deficient practice. The investigation of complaints included: Observation of grooming and physical appearance of residents, odors, staffing, meal observation, temperature of the facility, construction areas, posting of letter grade, and a tour of the facility including the memory care. Interviews were conducted with residents, Caregivers, Resident Care Coordinator, Expressions Director, Dietary Manager, Maintenance, and the Administrator. Record Review of five resident and five employee records, which included the resident of concern. Document Review included facility policy and procedures, incident reports, menus, staffing schedule, and invoices for repairs. 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. The following regulatory deficiencies were identified:	0000					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER Name:
REPRESENTATIVE'S SIGNATURE

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.