

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 09/27/2018
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 0000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG 0000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Initial Comments - Inspector Comments: This Statement of Deficiencies was generated as a result of an annual survey conducted at your facility on September 27, 2018. This State Licensure Survey was conducted in accordance with Nevada Administrative Code (NAC), Chapter 449, Residential Facility for Groups. The facility is licensed for 8 Residential Facility for Group beds for person with Alzheimer disease, Category II residents. The census at the time of the survey was seven. The facility received a grade of A. The finding and conclusion 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. There were no regulatory deficiencies identify. No further action necessary. Please retain a copy for your records.			

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 Name: _____ Title: _____ Date: _____
REPRESENTATIVE'S SIGNATURE