

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 6/15/2026
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/05/2023	
NAME OF PROVIDER OR SUPPLIER BELLA CARE HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 5905 CONCERT DR, LAS VEGAS, NEVADA ,89107			
(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 completed in your facility on 10/05/23, in accordance with Nevada Administrative Code, Chapter 449, Requirements for Residential Facilities for Groups. The facility is licensed for ten Residential Facility for Group beds for elderly or disabled persons and/or persons with Alzheimer's disease or related dementia, Category II. The census at the time of the survey was nine. The sample size was nine residents and three employees. The facility received a grade of A. There was one complaint was investigated: Unverified: Complaint #NV00069496 could not be verified. No regulatory deficiencies could be identified. The investigation in to the complaint included: Observations of Caregivers providing care and assistance to residents, and observations of nine residents with water and beverages available at bed side / chair side. Interviews were conducted with the Administrator, two Caregivers, nine residents, and two Hospice employees. Clinical record review of nine residents, including the Resident of Concern. Document review included policies regarding admission criteria and admission / discharge of residents, Resident Rights, and employee training. 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. There were no regulatory deficiencies identified. No action is necessary. Please retain this Statement for your records.	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.