

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 12/05/2023	
NAME OF PROVIDER OR SUPPLIER BELLA ESTATE CARE HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 3140 COACHLIGHT CIRCLE, LAS VEGAS, NEVADA ,89117			
(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 survey completed in your facility on 12/05/23, 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, Category II Residents. The census at the time of the survey was nine. Two resident records were reviewed. The facility received a grade of A. Unverified: 1. Complaint #NV00069557 could not be verified. No regulatory deficiencies could be identified. The investigation in to the allegations included: - Interviews were conducted with the Owner and a Caregiver. -Record review of two residents, including the resident of concern. -Document review of the facility's Infection Control & Prevention Plan and the Resident Rights. The findings and conclusions of any investigation by the Health Division 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 identified. No further 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.