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 _____	**07/22/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA ESTATE CARE HOME	**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 an annual State Licensure survey and complaint investigation completed at your facility on 07/22/25, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for ten Residential Facility for Group beds for elderly and disabled persons and/or persons with mental illness, five Category I and five Category II residents. The census at the time of the survey was five. Five resident files and four employee files were reviewed. The facility received a grade of A. There were three complaints investigated. Substantiated without deficient Practice: 1. Complaint #NV00073098 was substantiated with no deficient practice. Unsubstantiated: 2. Complaint #NV00074116 could not be substantiated. No regulatory deficiencies could be identified. 3. Complaint #NV00073105 could not be substantiated. No regulatory deficiencies could be identified. The investigation of complaints included: Observation of grooming and physical appearance of residents, odors, staffing, people living in the home, how residents call for help, meal observation, and . Interviews were conducted with residents, Caregivers, and the Manager. Record Review of residents, which included the resident of concern. Document Review included facility policy and procedures, staff schedule, and the Medication Administration Record. 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. The following regulatory deficiencies were identified:	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: SUSAN SOWERS Title: administrator Date: 08/22/2025

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.

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0515 SS= D	Supervision and Treatment of Residents - NAC 449.259 & R043-22 Supervision and treatment of residents generally. (NRS 449.0302) 1. A residential facility shall ensure that the staff of the facility collaborate with each resident of the facility, the family of the resident and other persons who provide care for the resident, including, without limitation, a qualified provider of health care, as interpreted by section 8 of this regulation, to: (a) Develop a person-centered service plan for the resident; and (b) Review the person-centered service plan at least once each year.; Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 5 residents had an annual person-centered service plan (Resident #2). Findings include: Resident #2 (R2) R2 was admitted on 01/15/24, with diagnosis including dementia. R2's file revealed a person-centered service plan dated 06/06/24. R2's file lacked documented evidence of an annual person-centered service plan. On 07/22/25 in the morning, the Manager acknowledged R2 was missing the annual person-centered service plan and was unaware the service plan was required annually. Severity: 2 Scope: 1	0515	1. The facility will correct the deficiency by including the person-centered service plan as part of the scheduled paperwork to be completed for each resident annually. 2. The administrator and manager will ensure the deficient practice does not recur by checking residents files monthly to make sure their person centered service plans are up to date and done annually. 3. The administrator and manager will monitor and be responsible for residents person-centered service plan to be in compliance during monthly checks of residents files and to have the person centered plan up to date. 4. The administrator and manager are responsible for ensuring that the deficiency practice will not recur. 5. The date of the corrective action was 7/22/2025	07/22/2025