

Bureau of Health Care Quality & Compliance

| | | | | |
|---|--|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS3287AGC | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 12/09/2008 |
| NAME OF PROVIDER OR SUPPLIER ASSISTED LIVING OF LAS VEGAS | | STREET ADDRESS, CITY, STATE, ZIP CODE 8204 CABIN SPRINGS AVE LAS VEGAS, NV 89131 | | |
| (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) COMPLETE DATE |
| Y 000 | <p>Initial Comments</p> <p>This Statement of Deficiencies was generated as a result of the annual state licensure survey and complaint investigation conducted at your facility on 12/09/2008.</p> <p>The survey was conducted using Nevada Administrative Code (NAC) 449, Residential Facility Groups Regulations, adopted by the Nevada State Board of Health on July 14, 2006.</p> <p>The facility was licensed for 9 total beds.</p> <p>The facility had the following category of classified beds: Category 2 - 9 beds</p> <p>The facility had the following endorsements: Residential facility which provides care to elderly and/or disabled person.</p> <p>The census at the time of the survey was 4. Four resident files and 3 discharged resident files were reviewed and 4 employee files were reviewed.</p> <p>There were 2 complaint(s) investigated during the survey.</p> <p>Complaint # NV14739 was unsubstantiated. Complaint # NV17088 was unsubstantiated.</p> <p>The findings and conclusions of any investigation by the Health Division 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.</p> <p>There were no deficiencies identified during the survey. No further action is necessary concerning this report. Please retain this copy for</p> | Y 000 | | |

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

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

Bureau of Health Care Quality & Compliance

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS3287AGC | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 12/09/2008 |
|---|--|--|---|---|
| NAME OF PROVIDER OR SUPPLIER ASSISTED LIVING OF LAS VEGAS | | STREET ADDRESS, CITY, STATE, ZIP CODE 8204 CABIN SPRINGS AVE LAS VEGAS, NV 89131 | | |
| (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) COMPLETE DATE |
| Y 000 | Continued From page 1 your records. | Y 000 | | |

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.