

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS108AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/10/2011
NAME OF PROVIDER OR SUPPLIER CHARLESTON RESIDENTIAL CARE HOTEL		STREET ADDRESS, CITY, STATE, ZIP CODE 2121 W CHARLESTON BLVD LAS VEGAS, NV 89102		
(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>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>This Statement of Deficiencies was generated as a result of a complaint investigation conducted in your facility on 3/10/11 through 5/10/11. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division.</p> <p>The facility is licensed for 129 Residential Facility for Group beds for elderly and disabled person and/or persons with mental illness.</p> <p>Complaint #NV00027782 - The allegation regarding a resident being sexually abused was not substantiated through interview and document review.</p> <p>#NV00027782: The complaint investigative process was initiated by the Bureau of Health Care Quality and Compliance on 3/1/11.</p> <p>The investigation included:</p> <ul style="list-style-type: none"> - Interviews were conducted with the alleged victim who denied being touched inappropriately by a male resident. - Interviews were conducted with the alleged victims two roommates who stated a male resident was ever allowed in their bedroom. - Interviews were conducted with the facility Activities Coordinator, Resident Coordinator and 	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 and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS108AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/10/2011
NAME OF PROVIDER OR SUPPLIER CHARLESTON RESIDENTIAL CARE HOTEL			STREET ADDRESS, CITY, STATE, ZIP CODE 2121 W CHARLESTON BLVD LAS VEGAS, NV 89102		
(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 a caregiver of the facility who stated they never observed a male resident in the alleged victim's bedroom, nor did they observe the alleged victim inappropriately touched by a male resident. - Interviews were conducted with the alleged victim's mother. - An interview was conducted with an employee of the Las Vegas Metropolitan Police Department who stated a report was not filed, the case was advised only. - Review of correspondence of the Las Vegas Metropolitan Police Department regarding the alleged event was made confirming no police report filed, it was advised only.	Y 000			

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