Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11423	A. BUILDING _____ B. WING _____	07/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY AT MT HOOD	1566 MOUNT HOOD ST, LAS VEGAS, NEVADA ,89110

(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
RFG 0000- No Deficiencies	The Statement of Deficiencies was generated as a result of a state licensure survey conducted in your facility, in accordance with Nevada administrative code, chapter 449, and Nevada revised statutes chapter 449- Residential Facility for Groups (RFG), medical facilities and other related entities. The findings and conclusions of any investigation by the Division of Health Care Purchasing and Compliance shall not be construed as prohibiting any criminal civil investigation, actions or other claims for reliefs that may be available to any party under applicable federal, state or local law. The RFG was found to be in substantial compliance. No regulatory deficiencies were identified. No further action is necessary. Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation survey initiated at your facility on 07/29/26 in accordance with Nevada Administrative Code, chapter 449, and Nevada revised statues chapter 449 Residential Facility for Groups (RFG), medical facilities and other related entities. The facility is licensed for ten Residential Facility for persons with elderly and disabled and/or persons with Alzheimer's disease, Category II residents. The census at the time of the survey was five. Six resident files were reviewed (including the Resident of Concern). The facility received agrade of A. There were two complaints investigated.	RFG 0000- No Deficiencies		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: Title: Date:

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	Unsubstantiated: Complaint #NV00013875 could not be substantiated. No regulatory deficiencies could be identified. Complaint #NV00013890 could not be substantiated. No regulatory deficiencies could be identified. The investigation of the complaint included: Observation of facility environment, physical appearance of residents, meal observation, medication pass and tour of the facility. Interviews were conducted with residents, family members, caregivers and the Owner of the facility. Clinical Record Review of six records. Document Review included Medication policy, Medication Administration Records review, visiting hours, menus, Power of Attorney paperwork and resident care plans. No regulatory deficiencies were identified. No further action is necessary.			