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 _____	08/27/2026

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

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RFG 0001-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. Based on an inspection conducted, the items marked below identify the violation in operation of the RFG which must be corrected by the revisit/compliance date specified in writing by the health authority. Failure to comply with this notice and immediately correct the identified deficiencies may result in the suspension or termination of your provider agreement, funding, or future authorization as a provider authorized by the State	RFG 0001-Deficiencies		

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	of Nevada pursuant to NAC 433.384, and other applicable local and state laws. Inspector Comments: This Statement of Deficiencies was generated as a result of a Complaint Investigation completed at your facility on 08/27/26. The census at the time of the survey was zero. The sample size was one. The facility received a grade of C. There were two complaints investigated. Substantiated: 1. Complaint #14306 was substantiated. (See Tag Y0850) 2. Complaint #14329 was substantiated. (See Tag Y0850) The investigation of the complaint included: Public record review of Las Vegas Township Justice Court Records. Observations of the facility and back doorway. Interviews were conducted with a Caregiver and the Owner. Record Review of resident files were not available during the time of the survey.			
Y 0850 SS= J	NAC 449.274 and R043-22 **Medical care of resident after illness, injury or accident; periodic physical examination of resident; rejection of medical care by resident; written records.**	Y 0850	1) The Owner was re-trained when an incident occurs, such as a fall, hits their head, accident, any injury, illness, or physical or mental change is noticed (not their norm) with a Resident, the staff on duty must call 911 and resident's physician immediately to ensure immediate and timely medical care for the Resident is administered. All Caregivers will be re-trained when the facility re-opens.	09/11/2026

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	1. If a resident of a residential facility becomes ill or is injured, the resident's physician and a member of the resident's family must be notified at the onset of illness or at the time of the injury. The facility shall: (a) Make all necessary arrangement to secure the services of a licensed physician to treat the resident if the resident's physician is not available; and (b) Request emergency services when such services are necessary. 2. A resident who is suffering from an illness or injury from which the resident is expected to recover within 14 days after the onset of the illness or the time of the injury may be cared for in the facility. The decision as to the period within which the resident is expected to recover from the illness or injury and the needs of the resident must be made by the resident's physician or, if he is unavailable, by another licensed physician. 3. A written record of all accidents, injuries and illnesses of the resident which occur in the facility must be made by the caregiver who first discovers the accident, injury or illness. The record must include: (a) The date and time of the accident or injury or the date and time that the illness was discovered; (b) A description of the manner in which the accident or injury occurred or the manner in which the illness was discovered; (c) A description of the manner in which the members of the staff of the facility responded to the accident, injury or illness and the care provided to the resident. This record must accompany the resident if he or she is transferred to another facility. 4. The facility shall ensure that appropriate medical care is provided to the resident by: (a) A caregiver who is trained to provide that care; (b) An independent contractor who is trained to provide that care; or (c) A medical professional. 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by a qualified provider of health		The owner, RFA, and responsible party must then be notified right after medical care is provided. When the resident's medical care has been attended to, the staff must complete an Incident Report Form with detailed information and placed in the Incident Report binder, and a copy in the Resident's file as well; moving forward. 2) Facility will follow the above procedures to ensure immediate medical care for the resident is provided; call 911 and the physician. Call responsible parties, and complete Incident Report form and file them. The proper details of completing the Incident Report will be retrained to the owner and all staff. A log of training, signed and dated will be kept in the facility. 3) Moving forward, the owner and RFA will check monthly or more often as when an incident occurs, the Incident Report Binder's contents. When an Incident Report is made, the RFA will review the Incident Report with the staff making the form for clarity and accuracy. Moving forward, all staff will be trained on how to better care for all residents, and in particular, the Resident of an incident. This includes adhering to the instructions as per the Resident's physician or the medical facility's discharge instructions. 4) The owner, the RFA, and all staff will be responsible to ensure the above procedures are followed, implemented, and monitored moving forward. 5) All of the above will be implemented immediately effective resuming operations. As of 8/21/2026, the facility has been closed, no residents or staff present, or files; files are with the Metro police.	

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	care in accordance with NRS 449.1845. The resident must be cared for pursuant to any instructions provided by the qualified provider of health care. 6. The members of the staff of the facility shall: (a) Ensure that the resident receives the personal care that he requires. (b) Monitor the ability of the resident to care for his own health conditions and shall document in writing any significant change in his ability to care for those conditions. 7. This section does not prohibit a resident from rejecting medical care. If a resident rejects medical care, an employee of the facility shall record the rejection in writing and request that the resident sign that record as a confirmation of his rejection of medical care. If the resident rejects medical care that a physician has directed the facility to provide, the facility shall inform the resident's physician of that fact within 4 hours after the care is rejected. The facility shall maintain a record of the notice provided to the physician pursuant to this subsection. 8. As used in this section, "significant change" means a change in a resident's condition that results in a category 1 resident becoming a category 2 resident or otherwise results in an increase in the level of care required by the resident. Inspector Comments: Based on interview, the facility failed to ensure a resident's physician and/or emergency medical services were contacted following a fall with a head injury (Resident #1). Findings include: A public record search revealed the owner had charges filed on 08/22/26 for the following: Felony Neglect older or vulnerable person, first offense and three felony charges - Obtain or possess credit or debit card without cardholders consent.			

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	Resident #1 (R1) R1 was admitted on 08/17/26, with a diagnosis of Alzheimer's disease. On 08/27/26, there was no documentation the facility had an Administrator. On 08/27/26 at 8:45 AM, the Owner reported that on 08/19/26 at approximately 5:30 PM, R1 opened the back door, stumbled, struck R1's head on the door, and fell to the ground. The Owner reported R1 sustained a bruise near R1's left eye following the fall. R1 was not transported for emergency medical evaluation, 911 was not contacted, and the physician was not notified immediately following the resident's fall and head injury on 08/19/26. The Owner reported an incident report was not completed following the fall on 08/19/26 and indicated only a note was written on a piece of paper indicating the resident had fallen. The Owner reported on 08/20/26, R1 continued to appear agitated. On 08/21/26, R1 was difficult to rouse and would only blink R1's eyes without speaking. At approximately 3:00 PM, R1 remained difficult to rouse, and the Caregiver reported to the Owner R1 was not doing well and had shallow breathing. The Owner asked the Caregiver to monitor R1. At approximately 5:00 PM, the Caregiver notified the Owner that R1 had difficulty breathing. The Owner reported 911 was not contacted by the Caregiver immediately and was contacted by the Owner approximately 15 minutes after being notified of R1's difficulty breathing, upon the Owner's return to the facility. Emergency medical personnel arrived at approximately 5:30 PM to 5:45 PM and initiated Cardiopulmonary resuscitation (CPR). Paramedics pronounced R1 was deceased.			

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	The Owner reported the resident subsequently passed away on 08/21/26. The Owner additionally reported being arrested by Las Vegas Metropolitan Police on 08/21/26 for negligence related to R1's fall and death. Severity: 4 Scope: 1 Complaint #14306 and #14329			