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 _____	**05/16/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAS VEGAS CHATEAU FOR SENIORS	**4175 N TOMSIK ST, LAS VEGAS, NEVADA ,89129**

(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 a Complaint Investigation initiated at your facility on 04/19/19 through 05/16/19, in accordance with Nevada Administrative Code (NAC) Chapter 449, Agencies to Provide Personal Care Services In the Home. The census was nine. The sample size was five. There was one complaint investigated. Complaint #NV00056719 with the following allegations could not be substantiated: Allegation #1 A resident caught an infection while in the facilty. Allegation #2 A resident's pressure sore became worse while at the facility. Allegation #3 The resident developed pressure sores on the resident's heels. Allegation #4 The facility failed to administer a resident's antibiotics. Allegation #5 A resident's blood sugar was high. Allegation #6 A resident had a urinary tract infection. Allegation #7 A resident passed away from septic shock. Allegation #8 A resident was malnourished. The investigation into the allegations included: Observations of a tour of the facility, resident appearance, caregiver interactions, cleanliness of the facility, residents eating lunch and the food supply. Interviews were conducted with five residents, two caregivers and a home health nurse. Record review of five client records including the client of concern. Document review of the menu, records from the skilled nursing facility and home health agency. 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 investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. There were no regulatory deficiencies identified. No further action is necessary. Please retain a copy for your records.	0000		

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

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.