

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 9724	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/18/2019
NAME OF PROVIDER OR SUPPLIER BELLA CARE HOME, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 9900 VERMILLION CLIFFS AVE, LAS VEGAS, NEVADA ,89147		
(X4) ID PREFIX TAG 0000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG 0000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of the Change of Ownership Survey conducted at your facility on 07/18/19, in accordance with Nevada Administrative Code, Chapter 449, Residential Facilities for Groups. The facility has submitted an application to be licensed for 7 Residential Facility for Group beds for persons with Alzheimer's disease or related dementia, Category II. The census at the time of the survey was 5. Five resident records and six employee records were reviewed. 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 investigations, actions, or other claims for relief that may be available to any party under applicable federal, state, or local laws.			

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 Name: Title: Date:
REPRESENTATIVE'S SIGNATURE