STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11168	A. BUILDING _____ B. WING _____	11/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A AND J CARE HOME LLC	5217 W. GOWAN RD., LAS VEGAS, NEVADA ,89130

(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 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11168	A. BUILDING _____ B. WING _____	11/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A AND J CARE HOME LLC	5217 W. GOWAN RD., LAS VEGAS, NEVADA ,89130

(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
	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, annual survey initiated at your facility on 11/12/25. The facility is licensed for seven Residential Facility for Group beds for elderly and disabled persons and/or Mental Illness, Category II residents. The census at the time of the survey was five. five resident files and three employee files were reviewed. The facility received a grade of C. There was one complaint investigated. Substantiated: Complaint#NV00012506 was substantiated. (See Tags Y 0050 and Y0590) The investigation of Complaint included: Observation of physical appearance for residents, and a			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11168	A. BUILDING _____ B. WING _____	11/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A AND J CARE HOME LLC	5217 W. GOWAN RD., LAS VEGAS, NEVADA ,89130

(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
	tour of the facility. Interviews were conducted with residents, Caregivers and the Administrator. Clinical Record Review of six records, which included the resident of concern. Document Review included facility policy and procedures.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11168	A. BUILDING _____ B. WING _____	11/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A AND J CARE HOME LLC	5217 W. GOWAN RD., LAS VEGAS, NEVADA ,89130

(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
Y 0050 SS= G	NAC 449.194 Responsibilities of administrator. The administrator of a residential facility shall: 1. Provide oversight and direction for the members of the staff of the facility as necessary to ensure that residents receive needed services and protective supervision and that the facility is in compliance with the requirements of NAC 449.156 to 449.2766, inclusive, and chapter 449 of NRS. Inspector Comments: Based on interview, record review, and document review the Administrator failed to provide oversight and direction for the facility as necessary to ensure that residents receive needed services and protective supervision and that the facility was in compliance with the requirements of NAC 449.156 to 449.2766. Findings include: 1. (See TAG 0850) Severity: 3 Scope: 1	Y 0050	Administrator reviewed all current Residents to ensure compliance on 12/8/2025. All staff received new CPR/First Aid training on 12/13/2025 and Hospice Nurse provided a new training for all staff on Full Code versus DNR/POLST on 12/8/2025. All Care Staff will receive this Full Code training annually or as needed going forward. Administrator and/or Designee will ensure compliance going forward.	12/15/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11168	A. BUILDING _____ B. WING _____	11/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A AND J CARE HOME LLC	5217 W. GOWAN RD., LAS VEGAS, NEVADA ,89130

(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
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.** 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;	Y 0850	Administrator reviewed all current Residents to ensure compliance on 12/8/2025. All staff received new CPR/First Aid training on 12/13/2025 and Hospice Nurse provided a new training for all staff on Full Code versus DNR/POLST on 12/8/2025. All Care Staff will receive this Full Code training annually or as needed going forward. Administrator and/or Designee will ensure all Hospice Residents POLST or DNR are in their file if applicable. If no DNR/POLST or if it is unsigned, staff will immediately call 911 and perform CPR/First Aid until medical professionals arrive on site.	12/15/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11168	A. BUILDING _____ B. WING _____	11/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A AND J CARE HOME LLC	5217 W. GOWAN RD., LAS VEGAS, NEVADA ,89130

(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
	(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 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, record review and document			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11168	A. BUILDING _____ B. WING _____	11/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A AND J CARE HOME LLC	5217 W. GOWAN RD., LAS VEGAS, NEVADA ,89130

(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
	review an employee failed to perform cardiopulmonary resuscitation (CPR) and request medical services for a resident who was found unresponsive (Resident #6). Findings include: Resident #6 (R6) R6 was admitted to the facility on 10/30/2025 with a diagnosis of cerebral vascular disease and was under hospice care. The resident's file had an unsigned Physician Orders for Life-Sustaining Treatment (POLST) documenting to attempt resuscitation and provide full treatment with the goal being to prolong life by all medically effective means. R6's hospice provider provided a POLST signed by R6's physician and dated 10/30/2025 documenting to attempt resuscitation and provide full treatment with the goal being to prolong life			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11168	A. BUILDING _____ B. WING _____	11/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A AND J CARE HOME LLC	5217 W. GOWAN RD., LAS VEGAS, NEVADA ,89130

(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
	by all medically effective means. An incident report dated 11/03/2025 documented R6 woke upon 11/03/2025 at around 7:30 AM, ate breakfast and went back to sleep around 8:00 AM. About 30 minutes later Employee #2 (E2) went to check onR6 and found R6 unresponsive. E2 notified R6's hospice provider and the hospice nurse arrived and declared R6 had passed away. The incident report lacked documented evidence E2 contacted emergency services (911). On 11/12/2025 at 10:09 AM, E2 indicated on 11/03/2025 R6 woke up, ate breakfast and went back to sleep. E2verbalized after about 30 minutes E2 found R6 was unresponsive to E2 calling R6's name, and the hospice provider was notified. E2 indicated E2 did not perform CPR on R6 because it was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11168	A. BUILDING _____ B. WING _____	11/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A AND J CARE HOME LLC	5217 W. GOWAN RD., LAS VEGAS, NEVADA ,89130

(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
	the facility's policy when a resident was on hospice and was found unresponsive, the hospice provider was notified, and CPR was not attempted and/or performed. Additionally, E2 confirmed E2 did not call emergency services (911) after finding R6 unresponsive. E2 verified E2 was unaware R6 had a POLST and verified E2 did not check R6's POLST prior to contacting the hospice nurse. E2 explained when the hospice worker arrived 10minutes later, that the hospice nurse began CPR on R6. Employee #2 (E2) E2 was hired by the facility on 10/27/2015 as a Caregiver and had current CPR training completed on 02/20/2024 and valid until 02/20/2026. On 11/12/2025 at 11:04 AM, the Administrator indicated being unaware whether R6 had an advanced directive			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11168	A. BUILDING _____ B. WING _____	11/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A AND J CARE HOME LLC	5217 W. GOWAN RD., LAS VEGAS, NEVADA ,89130

(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
	or a Do Not Resuscitate (DNR) order. The Administrator indicated if a resident was on hospice and had a DNR the hospice provider would be notified first, and CPR would not have been performed. The Administrator went on to explain if a resident had a POLST to attempt resuscitation, CPR should be performed immediately when the resident is found unresponsive. The Administrator acknowledged R6 did not have a DNR and was full code, and verbalized E2 should have begun performing CPR and contacted emergency services once R6 was found unresponsive. The facility's policy titled Do Not Resuscitate dated10/30/2025 documented a Do Not Resuscitate (DNR) order signed by the patient's physician (or other authorized independent practitioner) must be on file			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11168	A. BUILDING _____ B. WING _____	11/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A AND J CARE HOME LLC	5217 W. GOWAN RD., LAS VEGAS, NEVADA ,89130

(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
	in the patient's clinical record and admission folder in the patient's home. If there is no DNR order or valid advanced directives and the patient expires in the presence of a CPR trained staff person, CPR will be initiated according to the American Heart Association's Basic Life Support (BLS). Severity: 4 Scope:1			