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
	12187	A. BUILDING _____ B. WING _____	07/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKE RANCH MEMORY CARE	7395 SMOKE RANCH RD, LAS VEGAS, NEVADA ,89128

(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, 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 facility 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 survey completed at your facility on 07/07/26. The census at the time of the survey was 58. The sample size was 5. The facility received a grade of A There were two complaints investigated. Substantiated without deficient practice. 1. Complaint #13800 was substantiated with no deficient practice. 2. Complaint #13907 was substantiated with no deficient practice. The investigation of the complaints included:	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:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	12187	A. BUILDING _____ B. WING _____	07/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMOKE RANCH MEMORY CARE	7395 SMOKE RANCH RD, LAS VEGAS, NEVADA ,89128

(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
	Observation of grooming and appearance of residents, staff to resident interactions, and a tour of the facility. Interviews were conducted with Caregivers, Medication Technicians, and the Administrator. Clinical Record Review of 5 records, which included the Residents of Concern. Document Review included facility policies and procedures, incident reports, APS reports, and recorded video.			