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
	12315	A. BUILDING _____ B. WING _____	09/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAM'S CARE HOME	7535 W GOWAN ROAD, 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
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
	12315	A. BUILDING _____ B. WING _____	09/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAM'S CARE HOME	7535 W GOWAN ROAD, 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
	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 State licensure bed increase survey conducted in your facility on 09/28/26, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facilities for Groups. The facility was licensed for five Residential Facility for Group beds for elderly and disabled persons and persons with Alzheimer's disease, Category II residents. The facility has applied for a five-bed increase and was not approved to add five group beds which provide services for elderly and persons and persons with Alzheimer's disease, for a total of 10 Category-II beds. The facility would be approved after the deficiencies were corrected. The census at the time of the survey was five.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	12315	A. BUILDING _____ B. WING _____	09/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAM'S CARE HOME	**7535 W GOWAN ROAD, 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
Y 0179 SS= F	NAC 449.209 6. All windows that are capable of being opened in the facility and all doors that are left open to provide ventilation for the facility must be screened to prevent the entry of insects. Inspector Comments: Based on observation and interview the facility failed to ensure resident's bedroom windows had a screen. Findings include: On 09/28/26 in the morning, a tour of the facility revealed all resident bedroom windows were without screens. On 09/28/26 in the morning, the Administrator acknowledged the missing screens for the resident bedroom windows. Severity: 2 Scope: 3	Y 0179	1. **Correction of Specific Finding:** All window screens have been properly installed/reinstalled. Each window is equipped with a secure and appropriately fitted screen. 2. **Measures/Systematic Changes to Prevent Recurrence:** The facility will include inspection of all operable windows and window screens as part of routine environmental safety checks. Staff will report any missing, damaged, loose, or improperly fitted screens to the Administrator / owner promptly so they can be repaired or replaced. 3. **Monitoring of Corrective Action:** Administrator and Owner 4. **Person Responsible: Administrator** 5. **Completion Date:** 09/28/2026	09/28/2026
Y 0995 SS= F	**NAC 449.2756 andR043-22** (f) The facility has an area outside the facility or a yard adjacent to the facility that: (1) May be used by the residents for outdoor activities; (2) Has at least40 square feet of space for each resident in the facility; (3) Is fenced; and (4) Is maintained in a manner that does not jeopardize the safety of the residents. All gates leading from the secured, fenced area or yard to an unsecured open area or yard	Y 0995	1. **Correction of Specific Finding:** The facility corrected the deficiency by installing fencing and a secured gate to fence in the outdoor area used by residents. The gate leading from the secured outdoor area to the unsecured area is equipped with a locking mechanism. Keys to the gate are maintained in a designated location that is readily accessible to facility staff at all times. 2. **Measures/Systematic Changes to Prevent Recurrence:** The facility will require the secured outdoor area, fencing, gate, and locking mechanism to be routinely inspected. Staff will ensure that the gate remains secured when not actively being used for authorized entry or exit and that gate keys remain readily available to staff at all times. Any damage, malfunction, or condition that could compromise the security or safety of the outdoor area will be reported immediately to the Administrator / owner and corrected promptly. 3. **Monitoring of Corrective Action:** The Administrator or designee will	09/29/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	12315	A. BUILDING _____ B. WING _____	09/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAM'S CARE HOME	7535 W GOWAN ROAD, 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
	must be locked and keys for gates must be readily available to the members of the staff of the facility at all times Inspector Comments: Based on observation and interview the facility failed to ensure the facility had an area outside of the facility or yard that may be used by residents in facility that was 1) fenced and locked for safety, and 2) had 40 square feet of space for each of the ten residents. Findings include: On 09/28/26 in the morning the inspector observed the outdoor patio area for resident activities to measure a total of two hundred and seventy square feet. On 09/28/26 in the morning, the Administrator verbalized they were unaware of the fenced outdoor requirements of 40 sq. ft per resident, but they would make necessary accommodations for the safety of the residents and to add the appropriate square footage of the outdoor area in order to be approved for the five bed increase bringing the census of the facility to ten residents. Scope: 2 Severity: 3		routinely inspect the outdoor area, fencing, gate, and locking mechanism to verify that the area remains secure and maintained in a manner that does not jeopardize resident safety. The Administrator or designee will also verify that gate keys remain readily available to staff. Any identified deficiency will be documented and corrected promptly. 4. **Person Responsible: Administrator / Owner** 5. **Completion Date: 09/29/2026**	