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 |
|---|---|---|---|
| | 12338 | A. BUILDING _____ B. WING _____ | 08/31/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DAWN GARDEN HOME CARE, LLC | 9190 DAWN GARDEN AVE, LAS VEGAS, NEVADA ,89147 |

| (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.<br><br>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.<br><br>The facility was found to be in substantial compliance. No regulatory deficiencies were identified. No further action is necessary.<br><br>Inspector Comments: This Statement of Deficiencies was generated as a result of an Annual Survey completed at your facility on 08/31/26.<br><br>The facility is licensed for eight Residential Facility for Group beds for elderly and disabled persons and/ mental illness, Category II residents.<br><br>The census at the time of the survey was three.<br><br>Three resident files and four employee files were reviewed.<br><br>The facility received a grade of A. | 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: