DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**03/27/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN SENIOR HOME GABRIEL	**2372 GABRIEL DRIVE, LAS VEGAS, NEVADA ,89119**

(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
0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation survey completed at your facility on 03/27/25 in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The census at the time of the survey was eight. The sample size was five. The facility received a grade of A. There was one of complaint investigated. Substantiated: Complaint #NV00073786 was substantiated (see Tag 0174). The investigation of Complaint included: Observation including tour of facility, including residents rooms, closets, bathrooms, kitchen and facility exterior. Interviews were conducted with residents, a Caregiver and the Administrator. Document Review included pest control and plumbing invoices. 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 investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following deficiency was identified: An additional deficiency not related to the complaint was identified:	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: DORA VALENTIN Title: Administrator Date: 04/14/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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0174 SS= F	Health& Sanitation-odors-hazards-insects-dirt - NAC 449.209 Health and sanitation. (NRS 449.0302) 4. To the extent practicable, the premises of the facility must be kept free from: (a) Offensive odors; (b) Hazards, including obstacles that impede the free movement of residents within and outside the facility; (c) Insects and rodents; and (d) Accumulations of dirt, garbage and other refuse. Inspector Comments: Based on observation and interview, the facility failed to ensure the home was free of rodents. Findings include: On 03/27/25, in the morning, rodent feces were observed in a residents room and closet, a hallway closet and the caregivers room. On 03/27/25, a resident indicated they had seen rats and mice in their room, including on the walls and in their closet. On 03/27/25, a Caregiver revealed there are rodents in the home, including inside resident rooms, closets and the caregivers room. On 03/27/25, in the morning, the Administrator confirmed they are aware of rodents in the home, but have not been able to completely get rid of them. Severity: 2 Scope: 3 Complaint #NV00073786	0174	Findings have been addressed with aggressive pest control measures. Mitchell Pest control was coming out every day for a week, every other day for several weeks and now we are down to weekly visits. Holes have been patched on the walls and in the roof. As of the date of writing this POC, all rodent issues have disappeared from the inside of the house but there are still traps in the outside and the efforts to ensure that rodents do not enter continue. Systematically, Administrator has required owner to continue the monthly pest control contract. Owner did have such a contract, but the company changed hands and it was missed. Administrator will require owner to show pest control invoices monthly to ensure that it is happening and have added a task item for caregivers to document and report to Administrator and owner if/when any droppings appear. Administrator offered a training to the staff to help them understand the signs and symptoms of rodents that may be common to our environment in Las Vegas. Administrator will monitor these observations and reports to ensure that this will not recur. Administrator will be responsible to ensure that this plan of correction is implemented and it was corrected on March 27, 2025.	03/27/2025

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0445 SS= F	Requirements and Precautions - NAC 449.229 Requirements and precautions regarding safety from fire. (NRS 449.0302) 3. An exit door in a residential facility must not be equipped with a lock that requires a key to open it from the inside unless approved by the State Fire Marshal or his or her designee. Inspector Comments: Based on observation and interview, the facility failed to ensure a door leading into the backyard did not require a code to re-enter the facility. Findings include: On 03/27/25, in the morning, the surveyor could not re-enter the home from the backyard due to the door having a lock on it which required a pass key to open. The door which led into the backyard automatically locked once the door was closed. On 03/27/25, in the morning, a Caregiver confirmed the door, which led into the backyard, automatically locked when the door was closed and required a pass key to reopen or had to be opened by someone inside and could trap residents outside. Severity: 2 Scope: 3	0445	To correct this finding, the lock was replaced, to ensure that it opens properly so no one could get stuck outside. Systematically, Administrator will check the locks on a monthly basis to ensure that none of them work improperly and to ensure that this finding does not recur. The Administrator is in charge of making sure that this doesn't recur and the replacement of the lock was completed on March 28, 2025. Attaching proof of the lock change.	03/28/2025