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 _____	**01/14/2026**

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 an annual State Licensure and complaint investigation survey completed at your facility on 01/14/26 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 nine. The facility received a grade of D. There were three complaints investigated. Unsubstantiated: 1. Complaint #NV00074610 could not be substantiated. Substantiated: 2. Complaint #NV00074615 was substantiated. (See TAG Y920) 3. Complaint #12449 was substantiated. (See TAG Y850) The investigation of the complaints included: Observation of residents on oxygen, unsecured medications and bedrails on resident beds. Interviews were conducted with residents, Caregivers and the Administrator. Clinical record review of resident records, including the residents of concern. Document review included facility policy and procedures and Incident Reports. The findings and conclusions of any investigation by the Division of Health Care Purchasing and Compliance 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 regulatory deficiencies were identified.	0000		
0104 SS= F	Personnel Files - Background Checks - NAC 449.200 Personnel files. (NRS 449.0302) 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (f) Evidence of compliance with NRS 449.122 to 449.125, inclusive. Inspector Comments: Based on record review and interview, the Administrator	0104	**2) Systemic Changes to Prevent Recurrence:** The facility acknowledges the deficiency and has completed a comprehensive audit of all personnel files. It was determined that the valid NABS clearance letter for Employee #2 was available but not readily accessible at the time of survey; this document was correctly placed in employee #2's personnel file, though this employee	01/17/2026

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | Name: ARMANDO RODRIGUEZ | Title: Administrator | Date: 04/29/2026

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**01/14/2026**

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
	failed to ensure 3 of 5 employees completed a background check, as required. (Employee #1, #2 and #4) Findings include: Employee #1 (E1) E1 had a 11/2025 hire date as the Administrator. E1's record documented a Nevada Automated Background Check System (NABS) Clearance Letter for another facility. E1's record lacked documented evidence of fingerprints for this facility. Employee #2 (E2) E2 had a 11/01/25 hire date as a Caregiver. E2's record documented fingerprints dated 11/25/25. E2's record lacked a NABS Clearance Letter. Employee #4 (E4) E4 had a 01/22/25 hire date as the Lead Caregiver. E4's record documented a NABS Clearance Letter for another facility. E4's record lacked documented evidence of fingerprints for this facility. On 01/14/26 in the afternoon, the Administrator confirmed the lack of NABS Clearance Letters for E1, E2 and E4. Severity: 2 Scope: 3		separated soon after. The clearance letter in Employee #4'sfile was not the latest update, but the correct one had already reflected this facility since May 2025. This clearance letter was properly filed and will be uploaded into the ALIS system for your review. No clearance letter was found for Employee #1, though it was expected to have been as #1 was the former Administrator. Moving forward, the facility has implemented an enhanced personnel file management system requiring verification that all NABS clearance letters are facility-specific, valid, and properly filed within 10 days of hire and continuously maintained. All personnel files will be reviewed at hire and routinely audited by the Administrator or designee to ensure ongoing compliance with NAC 449 requirements and prevent recurrence. **3)Monitoring of Corrective Actions:** The Administrator or designee will conduct monthly audits of 100% of personnel files to ensure each file contains valid, facility-specific background check documentation. Any identified deficiencies will be corrected immediately upon discovery. **4)Responsible Position:** Administrator **5) Completion Date:** 01/17/2026 Employee#1 separation date was 02/01/2026 Employee#2 separation date was 01/30/2026	
0178 SS= F	Health & Sanitation - Maintain Int/ext - NAC 449.209 Health and sanitation. (NRS 449.0302) 5. The administrator of a residential facility shall ensure that the	0178	**3) Monitoring of Corrective Actions:** The Administrator or designee will conduct daily environmental rounds of the interior	04/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**01/14/2026**

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
	premises are clean and that the interior, exterior and landscaping of the facility are well maintained. Inspector Comments: Based on observation and interview, the facility failed to ensure the facility interior and exterior were maintained. Findings include: On 01/14/26 at 9:00 AM, observed the following: Interior: -Trash can in the kitchen did not have a lid and the exterior of the can had a layer of dirt and old food debris on it. -Cabinets and walls in the kitchen around the trash can had old food debris on them. -The toaster on the kitchen counter had old debris on the top and front of the unit. -The interior of the oven in the kitchen had a significant layer of baked on food debris, the oven window was covered with brown old baked on food debris. -The stove top had food debris on it and the exhaust fan under the hood had old food debris/grease had accumulated on it. -A gray hand towel hanging in the bathroom that was soiled. -The air exchange had a visible layer of dust on it. -A bucket with a mop and standing water in it. Exterior: -A mattress covered in plastic with miscellaneous wood on top of and under it were in the front yard. -Excessive weeds around the whole house. -Three windows on the East side of the house (including Room 3) lacked window screens. On 01/14/26 at 9:20 AM, the Caregiver confirmed the observations and indicated the interior and exterior needed to be maintained. Severity: 2 Scope: 3		and exterior of the facility for two weeks, followed by weekly inspections thereafter. A sanitation checklist will be used to verify cleanliness and maintenance of all required areas. A new trash can with lid was promptly purchased and placed in the kitchen. The specific items mentioned have been cleaned thoroughly. Photographs of all previously cited deficient conditions and corrected areas will be taken and uploaded to the ALIS system, in addition to those already submitted, to verify ongoing compliance and completion of corrective actions. All future findings and any deficiencies identified will be corrected immediately upon discovery. **4) Responsible Position:** Caregiver: Maintains cleanliness of interior and exterior areas during each shift and reports maintenance or sanitation concerns immediately. Administrator: Ensures cleaning systems, maintenance standards, and ongoing compliance monitoring are implemented and maintained. **5) Completion Date:** 01/15/2026 and throughout months of 02, 03 and 04 of 2026 **7)Identification of Other Affected Areas:** A comprehensive facility-wide audit of all interior and exterior areas was completed, and all identified issues related to kitchen sanitation, appliance and surface cleanliness, bathroom hygiene, ventilation dust, mop/laundry handling, and exterior maintenance (weeds, debris, and window screens) were corrected. The mattress and materials observed outside were staged for disposal pending the scheduled bulk pickup (every other Wednesday) and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	01/14/2026

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
			have since been removed; photos of the staging area will be uploaded. The facility had recently completed a broader cleanup of interior items and exterior debris, including tree waste. Exterior upkeep was further addressed with the purchase and use of lawncare equipment shortly before the survey, with continued maintenance performed afterward; updated photos will be uploaded. All areas have been restored to compliance, and ongoing cleaning and maintenance have been implemented, with additional photos to be uploaded as requested. The interior, including the kitchen, is being repainted in semi-gloss, cleanable white color in a safe process, where areas will only be painted when residents are in a safe, sanitary, and non-hazardous environment at all times, with proper precautions to protect residents from wet paint, chemical exposure or safety risks.	
0450 SS= E	First Aid & CPR - NAC 449.231 First aid and cardiopulmonary resuscitation. (NRS 449.0302) 1. Within 30 days after an administrator or caregiver of a residential facility is employed at the facility, the administrator or caregiver must be trained in first aid and cardiopulmonary resuscitation. The advanced certificate in first aid and adult cardiopulmonary resuscitation issued by the American Red Cross or an equivalent certification will be accepted as proof of that training. Inspector Comments: Based on record review and interview, the Administrator failed to ensure 2 of 5 employees had complete first aid and cardiopulmonary resuscitation (CPR) training within 30 days	0450	**2) Systemic Changes to Prevent Recurrence:** The facility completed a full review of all employee training and personnel files and determined that Employee #1 and Employee #2 did not obtain required First Aid and CPR certification within 30 days of hire; both were given opportunity to complete training but did not comply and are no longer employed (separation dates previously given and repeated below). It was also identified that prior administration did not consistently ensure NAC 449 compliance or maintain adequate tracking of required certifications. All remaining staff records were reviewed and verified as compliant. The facility has obtained a new	02/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	01/14/2026

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
	of hire. (Employee #1 and #2) Findings include: Employee #1 (E1) E1 had a 11/2025 hire date as the Administrator. E1's record documented CPR training dated 03/23/24. E1's record lacked documented evidence of first aid training. Employee #2 (E2) E2 had a 11/01/25 hire date as a Caregiver. E2's record lacked documented evidence of first aid and CPR training. On 01/14/26 in the afternoon, the Administrator confirmed the missing first aid and CPR training for E1 and E2. Severity: 2 Scope: 2		and well-qualified Administrator. Facility has implemented a mandatory tracking system requiring verification of First Aid and CPR certification within 30 days of hire, with all personnel files reviewed at onboarding and routinely audited by the Administrator or designee to ensure compliance, prevent lapses, and maintain continuous regulatory adherence. **3) Monitoring of Corrective Actions:** The Administrator will conduct weekly audits of all staff First Aid and CPR records to ensure compliance within the required 30-day timeframe. A training/ tracking log will be maintained and reviewed for each employee to verify completion status, expiration dates, and required documentation, with immediate corrective follow-up for any deficiencies identified. **4) Responsible Position:** Administrator: Ensures all staff complete required First Aid and CPR training within 30 days of hire and maintains compliance tracking. Caregiver: Completes required First Aid and CPR training and provides documentation within required timeframes. **5) Completion Date:** 02/01/2026 Employee#1 separation date was 02/01/2026 Employee#2 separation date was 01/30/2026.	
0690 SS= D	Residents Requiring Use of Oxygen - NAC 449.2712 Residents requiring use of oxygen. (NRS 449.0302) 1. A person who requires the use of oxygen must not be admitted to a residential facility or be permitted to remain as a resident of a residential facility unless he or she: (a) Is mentally and physically capable of	0690	**1)Correction of Specific Deficiency:** The oxygen equipment observed in Resident #1's room was secured properly after the time of discovery. All oxygen equipment in the facility was inspected to ensure each tank was properly secured in a	02/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**01/14/2026**

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
	operating the equipment that provides the oxygen; or (b) Is capable of: (1) Determining his or her need for oxygen; and (2) Administering the oxygen to himself or herself with assistance. 2. The caregivers employed by a residential facility with a resident who requires the use of oxygen shall: (a) Monitor the ability of the resident to operate the equipment in accordance with the orders of a physician; and (b) Ensure that: (1) The resident ' s physician evaluates periodically the condition of the resident which necessitates his or her use of oxygen; (2) Signs which prohibit smoking and notify persons that oxygen is in use are posted in areas of the facility in which oxygen is in use or is being stored; (3) Persons do not smoke in those areas where smoking is prohibited; (4) All electrical equipment is inspected for defects which may cause sparks; (5) All oxygen tanks kept in the facility are secured in a stand or to a wall; (6) The equipment used to administer oxygen is in good working condition; (7) A portable unit for the administration of oxygen in the event of a power outage is present in the facility at all times when a resident who requires oxygen is present in the facility; and (8) The equipment used to administer oxygen is removed from the facility when it is no longer needed by the resident. Inspector Comments: Based on observation and interview, the facility failed to ensure an oxygen tank was secured. Findings include: On 01/14/26 at 9:30 AM, observed an unsecured oxygen tank in the corner of a resident room (R1). On 01/14/26 in the morning, the Caregiver confirmed the oxygen tank was unsecured and should have been. Severity: 2 Scope: 1		stand or wall mount as required. Staff were instructed to verify oxygen equipment security during all resident care activities. Note: Resident 1 is vacating residence at time of upload. **3)Monitoring of Corrective Actions:** The Administrator or designee will conduct daily resident room checks for two weeks, followed by weekly audits thereafter, to ensure all oxygen equipment remains secure and compliant. Monitoring will include verification that oxygen tanks are properly stored in stands or wall mounts as required under NAC449.2712. Any deficiencies identified will be corrected immediately and documented during each audit cycle. **4)Responsible Position:** Caregiver: Ensures oxygen equipment is properly secured in approved stands or wall mounts during use and storage and reports any safety concerns immediately. Administrator: Ensures oxygen safety compliance, monitoring systems, and staff adherence to NAC 449.2712 requirements are implemented and maintained. **5)Completion Date:** 02/09/2026 **6)Required Safety Compliance Measures:** The facility ensures ongoing compliance with NAC 449.2712, including verification that oxygen equipment is properly secured, maintained in good working order, and used safely within resident care plans. Staff are expected to follow established safety protocols during all resident care interactions involving oxygen equipment. **7)Identification of Other Affected Areas:**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**01/14/2026**

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
			A facility-wide review of all residents receiving oxygen therapy was completed to ensure compliance with NAC 449.2712 requirements. "No Smoking" signs will remain posted in appropriate areas where oxygen is in use, and will be the policy of the facility entirely.	
0850 SS= D	Medical Care of Resident After Illness - NAC 449.274 Medical care of resident after illness, injury or accident; periodic physical examination of resident; rejection of medical care by resident; written records. (NRS 449.0302) 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 arrangements 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. Inspector Comments: Based on interview and record review, the facility failed to notify a resident's responsible party, a resident's physician, and complete an incident report after a discharge to the hospital for 1 of 9 sampled residents (Resident #9). Findings include: Resident #9 (R9) R9 was admitted on 10/10/25 with diagnoses including chronic obstructive pulmonary disease and heart failure and discharged to the hospital on 10/20/25. On 01/14/26 in the morning, the Lead Caregiver verbalized R9 was sent to the hospital due to chest pain, shortness of breath, and agitation on 10/20/25 and had not returned to the facility. Review of R9's file lacked documented evidence of communication by the facility to R9, their responsible party or R9's physician. R9's file lacked documented evidence of an incident report completed after R9's discharge to the hospital. The facility's Incident Reports	0850	**2) Systemic Changes to Prevent Recurrence:** The facility acknowledges that it failed to follow its established hospital transfer and illness escalation protocol in this isolated incident involving Resident #9. The facility already maintains a system requiring that all resident illness, injury, or hospital transfers be immediately documented through an incident report, with mandatory notification to the resident’s physician and responsible party or power of attorney at the time of the event, and documentation entered into a communication log within each resident record in accordance with NAC 449.274 requirements. Following this incident, all staff were retrained on the existing incident reporting, notification, admission, and discharge procedures to reinforce proper implementation of the established protocol and ensure consistent compliance moving forward. **3)Monitoring of Corrective Actions:** The Administrator or designee will review 100% of hospital transfers and significant change-of-condition events weekly for a period of 60 days, and monthly thereafter, to ensure incident reports are completed and that physician and responsible party notifications are documented. Each event will be verified for: completion of an incident report, documentation of physician notification, and documentation of family or POA notification.	01/15/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	01/14/2026

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
	procedure (undated) documented an Incident form is used to document and report any incident which is a threat to a resident's health, safety, welfare, or rights and the Administrator completes incident reports. On 01/14/26, the Lead Caregiver reported when a resident was discharged, an incident report and a discharge sheet should have been completed. The incident report should have documented if the family and physician were notified. On 01/14/26 in the morning, the Lead Caregiver verbalized R9, their responsible party and their physician were not notified of R9's reason for discharge. The Lead Caregiver confirmed an incident report was not completed for R9. Severity: 2 Scope: 1 CPT#12449		**4) Responsible Position:** Caregiver: Completes incident report and notifies physician and responsible party/POA immediately upon event. Administrator: Ensures documentation compliance through audits and training **5) Completion Date:** 01/15/2026 **6) Required Safety Compliance Measures:** The facility requires that any resident illness, injury, emergency transfer, or hospital discharge must be immediately documented through an incident report and discharge documentation, including verification that the resident's physician and responsible party have been notified at the onset of the event or at the time of transfer. All caregivers must ensure timely communication and documentation is completed without delay, and all records must be maintained in the resident file for compliance and review.	
0920 SS= F	Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 1. Medication, including, without limitation, any over-the-counter medication, stored at a residential facility must be stored in a locked area that is cool and dry. The caregivers employed by the facility shall ensure that any medication or medical or diagnostic equipment that may be misused or appropriated by a resident or any other unauthorized person is protected. Medications for external use only must be kept in a locked area separate from other medications. A resident who is capable of administering medication to himself or herself without supervision may keep the resident ' s medication in his or her room if the medication is kept in a locked container	0920	**1) Correction of Specific Deficiency:** The unlocked medication box in the refrigerator was immediately secured with a functioning lock, and all resident medications were returned to their designated locked storage areas. All over-the-counter items and personal care products observed outside of secured storage were immediately collected and placed into appropriate locked storage. Staff ensured all medication-related items were accounted for and secured at the time of correction. **2) Systemic Changes to Prevent Recurrence:**	01/14/2026

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 _____	**01/14/2026**

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
	for which the facility has been provided a key. 2. Medication stored in a refrigerator, including, without limitation, any over-the-counter medication, must be kept in a locked box unless the refrigerator is locked or is located in a locked room. Inspector Comments: Based on observation, document review and interview, the facility failed to ensure medications were secured. Findings include: On 01/14/26 at 9:30 AM, observed the following: The black medication box in the refrigerator had an open padlock on it with multiple resident medications. A 23-ounce jar of Metamucil Fiber Supplement was on the kitchen counter. A bottle of Complete Bath body wash and shampoo was sitting on the bathroom counter. A jar of Vicks Vaporub was on a bedside table in Room 3. A bottle of Eye Allergy Eye Drops was on a beside table for Resident #2. A bottle of Stool Softener tablets and a bottle of Allergy Relief drops was on the kitchen counter. The facility's Medication Storage policy (undated), documented all medications would be kept in locked storage at all times. If a resident is allowed to keep his/her own medications, locked storage is maintained in the resident's room to prevent access by other residents. The facility's Over-the-Counter Medications policy (undated), documented over the counter preparations are centrally stored in the same manner as prescription medications. On 01/14/26 in the morning, Employee #3 acknowledged leaving medications unsecured. On 01/14/26 in the afternoon, Employee #4 confirmed the unsecured medications and acknowledged the medications should have been secured. Severity: 2 Scope: 3 Complaint #NV00074615		The facility has reinforced medication storage procedures to ensure compliance with NAC 449.2748 requiring all prescription medications, over-the-counter medications, creams, drops, and any items capable of misuse to be stored at all times in locked, designated storage areas. The facility acknowledges that in this incident, medications and related items were not consistently secured as required and has clarified that no medications or resident care products are to be left unattended in resident rooms, bathrooms, kitchens, or common areas except during active administration under staff supervision, after which they must be immediately returned to secure storage. All staff have been retrained on medication handling and storage requirements, families have been reminded not to leave OTC medications or topical products in resident rooms, and daily monitoring of resident rooms has been implemented to ensure compliance moving forward. **3)Monitoring of Corrective Actions:** The Administrator or designee will conduct daily medication storage audits for two weeks, then weekly thereafter, to ensure all medications and related items remain secured. Caregivers will verify each shift that medication storage areas, including refrigerator lock boxes and carts, remain secured. Any unsecured item will be corrected immediately and documented. **4)Responsible Position:** Caregiver: Ensures medications and related items are secured immediately after use and reports unsecured items. Administrator: Ensures compliance system, training, and audits are implemented and maintained	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**01/14/2026**

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
			5)Completion Date: 01/14/2026 **6)Required Medication Safety Compliance Measure** All medications, including prescription and over-the-counter products, must remain in locked storage except during active administration. Refrigerated medications must be stored in a locked box unless the refrigerator is locked or located in a locked room. Caregivers are responsible for returning all medications and related items to secured storage immediately after use. **7)Identification of Other Affected Areas:** A facility-wide inspection of all medication storage areas, resident rooms, bathrooms, kitchen areas, and common spaces was completed. Any unsecured items identified were immediately removed and secured appropriately. It was noted that some items were present in open areas during active administration at the time of survey arrival; however, all such items must still be secured immediately after use, and this expectation has been reinforced.	
0966 SS= F	Alzheimer?s Care - NAC 449.2754 Residential facility which provides care to persons with Alzheimer ' s disease: Application for endorsement; general requirements. (NRS 449.0302) 3. The administrator of such a facility shall prescribe and maintain on the premises of the facility a written statement which includes: (b) Evidence that the facility has established interaction groups within the facility which consist of not more than six residents for each caregiver during those hours when the residents are awake;	0966	**2) Systemic Changes to Prevent Recurrence:** The facility reinforced staffing procedures to ensure consistent caregiver coverage for residents receiving Alzheimer's care services. The facility maintains a minimum of two caregivers during waking hours and one awake staff member during nighttime hours based on current census and care needs. The facility acknowledges that staffing coverage during the survey was later confirmed through video review and	01/14/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**01/14/2026**

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
	Inspector Comments: Based on observation, document review and interview, the facility failed to ensure there was adequate staff to provide care for eight residents. Findings include: On 01/14/26 at 8:45 AM, upon entry into the facility observed a Caregiver providing care. There were eight residents in the facility. There was no other Caregiver in the facility providing care to the eight residents. On 01/14/26 at 8:45 AM, there was no Staffing Schedule available to document who was assigned for the day shift. The Lead Caregiver explained work shifts were 7:00 AM to 6:00 PM and 6:00 PM to 7:00 AM. The Caregiver confirmed being the only Caregiver present, and explained another new Caregiver had not arrived as of 9:20 AM. On 01/14/26 at 9:25 AM, another Caregiver arrived to begin work. Severity: 2 Scope: 3		reconciliation to include two caregivers beginning at 7:00 AM. Additional staff arrived later to assist, including a third caregiver at approximately 9:20 AM, Employee #5 providing brief administrative support a while later, and Employee #1 arriving later yet to assist with the survey process. The posted daily staffing schedule was not present in its allotted space at the time of survey entry. This was an oversight that has been corrected. The facility now requires that staffing schedules are consistently posted, properly maintained, and retained for a minimum of six months for verification and compliance monitoring. **3) Monitoring of Corrective Actions:** The Administrator or designee will conduct daily verification of posted staffing schedules and weekly audits of retained scheduling records for a minimum of six months to ensure compliance. Staffing coverage will be reviewed against resident census daily to confirm that minimum caregiver requirements are met during all shifts. Any discrepancies will be addressed immediately and documented. **4) Responsible Position:** Caregiver: Provides direct resident care and reports staffing or coverage concerns immediately. Administrator: Ensures staffing schedules are posted, retained, and compliance monitoring systems are maintained **5) Completion Date:** 01/14/2026 **6) Required Safety Compliance Measures:** The facility maintains required staffing levels for residents with Alzheimer's	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	01/14/2026

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
			disease, including a minimum of two caregivers during waking hours and one awake staff member during nighttime hours, (adjusted only based on tentative resident census and acuity). Staffing schedules are maintained, posted, and retained for staff order, regulatory review, and internal auditing.	
0991 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 and R043-22 Residential facility which provides care to persons with Alzheimer ' s disease: Standards for safety; personnel required; training for employees. (NRS 449.0302) 1. The administrator of a residential facility which provides care to persons with Alzheimer ' s disease or other forms of dementia who meet the criteria prescribed in paragraph (a) of subsection 2 of NRS 449.1845 shall ensure that: (b) Operational alarms, buzzers, horns or other technology for notifying staff when a door is opened are installed on all doors that may be used to exit the facility. Inspector Comments: Based on observation and interview, the facility failed to ensure gates leading to the street were secured. Findings include: On 01/14/26 at 9:18 AM, during a tour of the facility observed one gate unsecured with a lock hanging beside the gate enclosure. A second gate was observed with an open lock. There was a yellow rope tied to the gate, extended and tied to a nearby pole. On 01/14/26 in the morning, the Administrator confirmed the gates were not secured and the yellow rope was not a securing mechanism for the gate. Severity: 2 Scope: 3	0991	**1) Correction of Specific Deficiency:** The unsecured gate with the hanging lock was immediately secured, and staff were re-instructed that all exterior access points must be fully locked after each use. The second gate, which had been temporarily secured with a rope due to a broken latch, was corrected with a properly installed latch mechanism and padlock system to ensure secure closure. The temporary rope was removed. It was noted that the first gate was left unlocked after caregiver use earlier that morning, and corrective re-education was completed to ensure immediate re-locking after entry or exit. **2) Systemic Changes to Prevent Recurrence:** The facility reinforced the requirement that all exterior gates and exit points must remain secured with functional locking mechanisms at all times, and temporary measures (such as ropes or makeshift ties) are not permitted as substitutes for approved locking systems. Staff were re-educated on	01/20/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**01/14/2026**

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
			immediate re-securing of gates after each use. The facility ensured that all gates were evaluated and repaired as needed to provide properly secured closure. 3) Monitoring of Corrective Actions: The Administrator or designee will conduct daily checks of all exterior gates and exit points for two weeks and weekly thereafter to ensure all access points remain secured and operational alarms or locking mechanisms are functioning as required. Caregivers will verify gates are locked after each use and immediately report any mechanical issues or security concerns. 4) Responsible Position: Caregiver: Ensures gates are secured immediately after use and reports any unsafe or unsecured conditions. Administrator: Ensures maintenance, security systems, and compliance monitoring of all exit points. 5) Completion Date: 01/20/2026 6) Required Safety Compliance Measures: All exterior gates and exit points must always remain secured when not actively in use. Any malfunctioning latch, lock, or securing mechanism must be immediately reported and repaired. Temporary measures are not to be used except when actively monitored and followed by prompt permanent repair.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**01/14/2026**

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
0994 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 and R043-22 Residential facility which provides care to persons with Alzheimer ' s disease: Standards for safety; personnel required; training for employees. (NRS 449.0302) 1. The administrator of a residential facility which provides care to persons with Alzheimer ' s disease or other forms of dementia who meet the criteria prescribed in paragraph (a) of subsection 2 of NRS 449.1845 shall ensure that: (e) Knives, matches, firearms, tools and other items that could constitute a danger to the residents of the facility are inaccessible to the residents. Inspector Comments: Based on observation and interview, the facility failed to ensure toxic substances and items that could constitute a danger to residents were secured. Findings include: On 01/14/26 at 8:57 AM, there was a spray can of Wall Texture and bottle of Oxyool Ultra under an unlocked kitchen sink. There was an open padlock on the cabinet. A drawer in the kitchen that contained multiple pairs of scissors, a screwdriver and other miscellaneous sharp objects was unlocked. There was a large butcher knife in the kitchen sink with food debris on it. On 01/14/26 in the morning, the Caregiver confirmed the observations, acknowledged the drawer and cabinet should have been secured and that the butcher knife should not have been laying in the sink. Severity: 2 Scope: 3	0994	**1) Correction of Specific Deficiency:** All hazardous items identified at the time of survey, including the spray can of wall texture, cleaning solution, scissors, screwdriver, and other sharp objects, were immediately removed from accessible areas and secured in locked cabinets and drawers. The cabinet under the sink was secured with a functioning lock, replacing the previously open padlock. The kitchen drawer containing sharp objects, as well as other select drawers, had all related contents relocated to a locked cabinet. The butcher knife observed in the sink was immediately removed, cleaned, and placed into the locked cabinet. Caregivers were immediately re-instructed that all knives, tools, chemicals, and hazardous items must be always secured when not in active use and may not be left unattended, even temporarily. A new gate was installed to ensure secondary deterrence to kitchen access. Defective drawers are soon being rebuilt and the kitchen repainted (in accordance with the safety measures outlined in Y178). **3) Monitoring of Corrective Actions:** The Administrator or designee will conduct and document daily environmental safety checks for two weeks and weekly thereafter, specifically verifying that all hazardous items, including knives, tools, and chemicals, are properly secured. Caregivers will conduct and document shift-based safety checks of kitchens, storage areas, and common areas to	01/15/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	01/14/2026

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
			ensure compliance throughout each shift. Any unsecured item identified will be immediately secured, documented, and reported to the Administrator for follow-up. **4) Responsible Position:** Caregiver: Ensures all hazardous items are secured immediately after use and performs ongoing safety checks during each shift. Administrator: Ensures safety policies, training, audits, and compliance monitoring systems are implemented and maintained **5) Completion Date:** 01/15/2026 **6) Required Safety Compliance Measures:** The facility maintains that all knives, tools, chemicals, cleaning agents, and any items that could pose a danger to residents will always be secured in locked cabinets or drawers when not in active use. Caregivers are required to maintain direct supervision of such items during use and to secure them immediately after use. All storage areas used for hazardous items must remain locked and in proper working condition. No hazardous items are permitted to remain accessible to residents at any time. **7) Identification of Other Affected Areas:** A facility-wide inspection of all areas	

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 _____	**01/14/2026**

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
			including kitchen, storage cabinets, drawers, and maintenance areas was completed to ensure no additional hazardous items were accessible to residents. The entire residence was inspected, and any questionable items were immediately removed/secured.	