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
	9397	A. BUILDING _____ B. WING _____	05/27/2026

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

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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		

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	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 mandatory regrading State Licensure survey conducted at your facility on 05/27/26, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 10 Residential Facility for Group beds for elderly and disabled persons and/or Alzheimer's disease, Category II residents. The census at the time of the survey was ten. Five resident files and three employee files were reviewed. The facility received a grade of A. The following regulatory deficiencies were identified.			
Y 0053 SS= D	**NAC 449.194**	Y 0053	1. How the specific finding was corrected: Records for Resident #4 and Resident #5 were reviewed and all missing admission documentation was obtained, completed,	06/03/2026

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	4. Ensure that the records of the facility are complete and accurate. Inspector Comments: Based on document review, record review and interview, the Administrator failed to ensure records were complete for 2 of 5 residents sampled. (Resident #4 and #5) Findings include: Resident #4 (R4) R4 was admitted on 05/07/26 with diagnoses including metabolic encephalopathy, altered mental state and anxiety. On 05/27/26 at 11:45 AM, R4's file lacked documented evidence of an Activities of Daily Living Assessment (ADL), a two-step TB test and a Person-Centered Care Plan. Resident #5 (R5) R5 was admitted on 05/19/26 with a diagnosis including Alzheimer's disease. On 05/27/26 at 11:35 AM, R5's file lacked documented evidence of a physical examination, an ADL Assessment, a two-step TB test, an initial signs and symptoms review, a Person-Centered Care Plan and an Ultimate User Agreement. The facility had oversight to manage R5's medication. The facility's Day of Admission/Move-In policy (undated), documented the Administrator coordinated the following on move-in day to ensure appropriate resident care: all preadmission documentation complete and in the resident's chart; the service plan was completed and all physician admission orders were received. The facility's Service Plans policy (undated), documented the Service Plan was developed with assistance and review from the resident/responsible party; the		and filed. For Resident #4 all of the following documents were confirmed within the file within days of the resurvey, and before the results of that survey were made available: Activities of Daily Living Assessment (ADL), a two-step TB test and a Person-Centered Care Plan. For Resident #5 the same was ensured within the same timeframe regarding the following documents: Physical examination, ADL Assessment, a twostep TB test, an Initial Signs and Symptoms Review, a Person-Centered Care Plan and an Ultimate User Agreement. The facility is alarmed by this shortcoming and takes it seriously; all10 Resident Files were ensured to have been completed. A recent attempt at using new filing tabs is noted as compounding the issue, and is being considered for further revision. The facility is also creating and implementing a number of new documents (i.e. a new Person-Centered Care Plan designed to better satisfy all of HCQC, Medicaid, and Ombudsmen). 2. What measures or systematic changes were put into place to ensure the deficient practice does not recur: The facility does not intend to allow this error to reoccur again. The Administrator is to immediately complete a 100% audit of all resident records using the facility's new and broader Resident Record Audit Checklist. Monthly audits of all resident records will be conducted for six months, and audit logs will be maintained for review by HCQC. 1. How the corrective actions will be monitored to ensure the deficient practice does not recur: Caregivers will complete an admission checklist for each admission. The Administrator will ensure monthly audits are conducted of new admissions for six months to ensure all required documentation is complete and accurate. Identified	

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	Administrator/designee, etc. The service plan should address ADLs and medication management. A copy of the service plan, signed by the resident and/or responsible party was retained in the resident's record. On 05/27/26 at 11:35 AM, the Administrator confirmed the missing documentation for R4 and R5. On 05/27/26 at 11:45 AM, the Caregiver reported the lead Caregiver for the day was responsible for the completion of resident forms at admission. The Administrator reported checking in with the facility weekly. On 05/27/26 in the morning, the Administrator reported R4 and R5 were receiving medications and had the understanding that a UUA must be completed prior to administering medications. Severity: 2 Scope: 1		deficiencies will be corrected immediately. 1. Title of the person(s) responsible for ensuring the plan of correction is implemented: Caregiver: Responsible for obtaining, completing, and filing admission documentation. Administrator: Responsible for oversight, auditing records, and ensuring compliance. 1. Date corrective action was completed: Corrective action was completed on 5/28 - 6/3/2026. 1. Supporting documents: A new monthly audit system checklist, applied to all resident records, will be attached to the ALIS system.	
Y 0994 SS= F	**NAC 449.2756** **Residential facility which provides care to persons with Alzheimer's disease: Standards for safety; personnel required;** (e) Knives, matches, firearms, tools, and other items that could constitute a danger to the residents of the facility are inaccessible to the residents. (g) All toxic substances are not accessible to the residents of the facility. Inspector Comments: Based on observation and interview, the facility failed to ensure that items that could	Y 0994	1. How the specific finding was corrected: The weed wacker, cigarette lighter, paint cans, and other hazardous items identified during the survey were immediately removed from resident-accessible areas and secured. The facility notes the weed wacker is routinely stored without the battery installed when not in use and is equipped with a double-lock safety mechanism. To ensure compliance with HCQC requirements, the equipment will be stored in a secured location inaccessible to residents when not in use. A facility-wide inspection of indoor and outdoor areas was completed and all hazardous items were secured. 1. What measures or systematic changes were put into place to ensure the deficient practice does not recur:	05/27/2026

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	constitute a danger to residents were secured. Findings include: On 05/27/26 at 9:50 AM, observed a weed wacker and cigarette lighter on a table on the back patio. Observed multiple paint cans placed just outside of the patio door. On 05/27/26 at 11:45 AM, the Caregiver acknowledged the observation and reported residents did go in and out of the backyard. This was a repeat deficiency from the 01/14/26 annual State Licensure survey and complaint investigation. Severity: 2 Scope: 3		Caregivers will conduct daily inspections and securing of resident-accessible areas, and hazardous items. The Administrator is responsible for oversight of environmental safety practices and verification of compliance with NAC 449.2756. 1. How the corrective actions will be monitored to ensure the deficient practice does not recur: Caregivers will complete and document daily environmental safety checks. The Administrator will conduct weekly environmental safety audits for 60 days, then monthly thereafter, to ensure compliance. Identified deficiencies will be corrected immediately. 1. Title of the person(s) responsible for ensuring the plan of correction is implemented: Caregiver: Responsible for daily environmental safety checks and securing hazardous items. Administrator: Responsible for oversight, audits, and ensuring compliance with NAC 449.2756. 1. Date corrective action was completed: Corrective action was completed on 5/27/2026.	