

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 4101	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/08/2026
NAME OF PROVIDER OR SUPPLIER LAKE MEAD CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 4325 W LAKE MEAD BLVD, LAS VEGAS, NEVADA ,89108-2849		
(X4) ID PREFIX TAG RFG 0001- Deficiencies	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG RFG 0001- Deficiencies	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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			

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 Name: GEOFFREY GOMEZ Title: Administrator
REPRESENTATIVE'S SIGNATURE

Date: 01/23/2026

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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 an annual State Licensure survey completed at your facility on 01/08/26 in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for six Residential Facility for Group beds for elderly and disabled persons and/or persons with mental illness, Category II residents. The census at the time of the survey was three. Three resident files and three employee files were reviewed. The facility received a grade of A.			
Y 0172 SS= F	NAC 449.209 2. Containers used to store garbage outside of the facility must be kept reasonably clean and must be covered in such a manner that rodents are unable to get inside the containers. At least once each week, the containers must be emptied, and the contents of the containers must be removed from the premises of the facility. 3. Containers used to store garbage in the kitchen and laundry room of the facility must be covered with a lid unless the containers are kept in an enclosed cupboard that is clean and prevents infestation by rodents or	Y 0172	A) All residents have the potential to be affected by the deficient practice. B) The following deficiencies are met and fixed. Paint peeling from ceiling, bedroom #3 hole in the on the wall, furnace filter replaced, exposed cable wiring removed, metal iron screen, gate, metal dolly and old crates have been discarded. See attachment. C) The Administrator and the staff will ensure the cleanliness and maintenance of the premises, accessibility to all residents for enjoyment surrounding yard must be free of debris. See attachment. D) Completed: 1/15/2026	01/15/2026

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	insects. Containers used to store garbage in bedrooms and bathrooms are not required to be covered unless they are used for food, bodily waste or medical waste. 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. 5. The administrator of a residential facility shall ensure that the 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 premises were clean and well maintained. Findings include: The following observations were made on 01/08/26 in the morning: - The paint on ceiling in the pantry adjacent from the kitchen was bubbling, peeling and hanging from the ceiling.			

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	- Bedroom #3 had a visible hole in the wall of alongside Resident 2 (R2)'s bed. - The hallway furnace intake filter was heavily soiled. - There was peeling painted on the exterior stucco by the the living room window. - There was exposed cable wiring on the exterior which was connected to NV Energy meter. -The debris pile on the retaining wall included (5) old iron screen doors, discarded white baby gate, discarded red metal dolly, (2) old crates. On 01/08/26 in the morning, the Owner acknowledged the damaged pantry ceiling, the soiled furnace intake filter, the hole in R2's bedroom, the exterior exposed wiring, the exterior peeling paint and the items in the debris pile . Severity: 2 Scope: 3			
Y 0515 SS= F	NAC 449.259 Supervision of residents. 1. A residential facility shall ensure that the staff of the facility collaborate with each resident of the facility, the family of the resident and other persons who provide care for the resident, including, without limitation, a qualified provider of health care, as interpreted by section 8 of this regulation, to:	Y 0515	Y 0515 A) All residents have the potential to be affected by the deficient practice. The person centered service plan for the three residents have been established and in file to be updated yearly. See attachment. B) The Administrator of the facility will ensure the accuracy of all residents file are up to date. See attachment. C) Completed: 1/15/2026	01/15/2026

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	(a) Develop a person-centered service plan for the resident; and (b) Review the person-centered service plan at least once each year. 2. A person-centered service plan developed pursuant to this section must include, without limitation: (a) Provisions concerning activities of daily living, medication management, cognitive safety, assistive devices, special needs, social and recreational needs and involvement of ancillary services; (b) Protective supervision as necessary for the resident; (c) The manner in which all caregivers will be informed of the required supervision of the resident; (d) The manner in which the facility will ensure that the resident has the opportunity to attend the religious service of his or her choice and participate in personal and private pastoral counseling; (f) Permission for the resident to enter or leave the facility at any time if the resident: (1) Is physically and mentally capable of leaving the facility; and (2) Complies with the rules established by the administrator of the facility for leaving the facility; (g) Laundry services for the resident unless the resident elects in writing to make other arrangements; (h) The manner in which the facility will ensure that the resident's clothes are clean, comfortable and presentable; (i) A requirement that the facility must inform the resident or his or her representative of the actions that the resident should take to protect the resident's valuables; (j) A written program of activities for the resident that includes scheduled and unscheduled activities that are suited to his or her interests and capacities; Inspector Comments: Based on record review and interview, the facility failed to develop a person-centered			

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	service plan with all the required components for 3 of 3 residents admitted to the facility. (Resident #1, #2, and #3). Findings include: Resident #1 (R1) R1 was admitted on 11/25/25 with primary diagnoses including stenosis, right leg deep vein thrombosis, non st-elevation myocardial infraction, major depressive disorder. R1's record lacked a person-centered service plan with the required components. Resident #2 (R2) R2 was admitted on 04/22/20 with primary diagnoses including schizophrenia. R2's record lacked a person-centered service plan with the required components. Resident #3 (R3) R3 was admitted on 09/20/16 with primary diagnoses including major depressive disorder. R3's record documented an initial plan of care included in the activities of daily living assessment dated 09/16/16 with the last annual review date as 08/16/24. R3's record lacked a person-centered service plan with the required components. On 01/08/26 in the afternoon, the Owner provided a document "PLAN OF CARE/ADL" and indicated this was the facility's person-centered service plan. The			

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	document lacked the following components: - Provisions concerning assistive devices, special needs, social and recreational needs and involvement of ancillary services. - The manner in which all caregivers would be informed of the required supervision of the resident. - The manner in which the facility would ensure the resident had the opportunity to attend the religious service of his or her choice and participate in personal and private pastoral counseling. - Permission for the resident to enter or leave the facility at anytime if the resident was physically and mentally able and within the guidelines established by the administrator of the facility for leaving the facility. - Laundry services for the resident unless the resident elected in writing to make other arrangements. - The manner in which the facility would ensure the resident's clothes were clean, comfortable and presentable. - A requirement the facility would inform the resident or his or her representative of the actions the resident should take to protect their valuables. - A written program of activities for the resident that included scheduled and unscheduled activities suited to his or her interests and capacities. On 01/08/26 in the afternoon, the Owner confirmed the facility had not developed a person-centered service plan with the			

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	required components for each resident. Severity: 2 Scope: 3			
Y 0870 SS= F	NAC 449.2742 Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall: (a) Ensure that a physician, pharmacist or registered nurse who does not have a financial interest in the facility: (1) Reviews for accuracy and appropriateness, at least once every 6 months the regimen of drugs taken by each resident of the facility, including, without limitation, any over-the-counter medications and dietary supplements taken by a resident; and (2) Provides a written report of that review to the administrator of the facility. (b) Include a copy of each report submitted to the administrator	Y 0870	Y 0870 A) The identified residents #1, #2, and #3 in regard to 6 months medication review has been corrected and initialed by the Administrator. B) The Administrator will ensure documentation for 6 months medication review, upon receipt will be sign within 72 hours. C) Completed: 01/15/2026	01/15/2026

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	pursuant to paragraph (a) in the file maintained pursuant to NAC 449.2749 for the resident who is the subject of the report. (c) Make and maintain a report of any actions that are taken by the caregivers employed by the facility in response to a report submitted pursuant to paragraph (a). Inspector Comments: Based on record review and interview, the facility failed to ensure six-month Medication Reviews were completed within 72 hours for 1 of 3 residents (Resident 1), and initialed and dated by the Administrator for 3 of 3 residents (Residents #1, #2, and #3). Findings include: Resident #1 (R1) R1 was admitted on 11/25/25 with primary diagnoses including stenosis, right leg deep vein thrombosis, non ST-elevation myocardial infraction, major depressive disorder. R1's file lacked documentation of a medication review within 72hrs. of admission, and the initials of the Administrator. Resident #2 (R2) R2 was admitted on 04/22/20 with primary diagnoses including schizophrenia.			

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	R2's file lacked documentation of a medication review and the initials of the Administrator. Resident #3 (R3) R3 was admitted on 09/20/16 with primary diagnoses including major depressive disorder. R3's file lacked documentation of a medication review and the initials of the Administrator. On 01/08/26 in the afternoon, the Owner confirmed the six-month Medication Reviews were not reviewed and should have been initialed and dated by the Administrator within 72 hours. Severity: 2 Scope: 3			