

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 11771	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/22/2026
NAME OF PROVIDER OR SUPPLIER WE CARE GOLDEN CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 3858 MOONGATE CIR, LAS VEGAS, NEVADA ,89103		
(X4) ID PREFIX TAG RFG 0000- No Deficiencies	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. The RFG was found to be in substantial compliance. No regulatory deficiencies were identified. No further action is necessary. Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation survey initiated at your facility on 01/22/26. The facility is licensed for ten Residential Facility for persons with elderly and disabled and/or persons with Alzheimer's disease, Category II residents. The census at the time of the survey was nine. Five resident files and four employee files were reviewed. The sample size was five (including the Resident of Concern). The facility received a grade of A. There was one complaint investigated. Unsubstantiated:	ID PREFIX TAG RFG 0000- No Deficiencies	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

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:
REPRESENTATIVE'S SIGNATURE

Title:

Date:

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 11771	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/22/2026
NAME OF PROVIDER OR SUPPLIER WE CARE GOLDEN CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 3858 MOONGATE CIR, LAS VEGAS, NEVADA ,89103		
(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
	Complaint #NV00012687 could not be substantiated. No regulatory deficiencies could be identified. The investigation of the complaint included: Observation of facility environment, physical appearance of residents, meal observation, medication pass and tour of the facility. Interviews were conducted with residents, Administrator, Owner of the facility. Clinical Record Review of five records. Document Review included Medication pass and Basic care needs. No regulatory deficiencies were identified. No further action is necessary.			