STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2726	A. BUILDING _____ B. WING _____	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMELA HOMES	**5500 CLEARY COURT, LAS VEGAS, NEVADA ,89109**

(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
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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2726	A. BUILDING _____ B. WING _____	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMELA HOMES	5500 CLEARY COURT, LAS VEGAS, NEVADA ,89109

(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 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 survey initiated at your facility on 09/04/2025. The facility is licensed for six Residential Facility for Group beds for persons with Mental Illness, and/or Elderly or Disabled Persons, Category II residents. The census at the time of the survey was five. Five resident files and five employees 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.	Y 0172	**1. Corrective Action Taken** As of 9/30/2025 , all debris and unused items listed in the citation (including rusted furniture, old bed frames, ladders, bird cage, paint trays, log, and wood debris) have been removed from the backyard. The dead log obstructing the side walkway was removed, and the uneven concrete slab was completed for repair 9/30/2025. Vents and light fixtures in the kitchen and	09/30/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2726	A. BUILDING _____ B. WING _____	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMELA HOMES	5500 CLEARY COURT, LAS VEGAS, NEVADA ,89109

(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
	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 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 extentpracticable, the premises of the facility must be kept free from: (a) Offensive odors; (b) Hazards, including obstacles that impede the freemovement of residents within and outside the facility; (c) Insects and rodents; and (d) Accumulations of dirt, garbage and other refuse. 5. Theadministrator of a residential facility shall ensure that the premises areclean and that the interior, exterior and landscaping of the facility are wellmaintained. Inspector Comments: Based on observations and interview, the facility failed to ensure the premises were clean and well maintained.		living/dining area were cleaned thoroughly on 9/15/2025. A deep cleaning of the facility was completed by owner on 9/15/2025. **2. Systemic Changes to Prevent Recurrence** • A facility-wide deep cleaning schedule has been implemented, with vents and fixtures to be cleaned at least monthly. • A monthly outdoor inspection checklist has been developed to ensure the backyard and all exterior areas are free from debris, hazards, and non-functional equipment. • Any item no longer in use will be discarded or stored appropriately within 7 days. • Staff were re-trained on the importance of maintaining a clean, safe, and clutter-free environment on 9/30/25. Training included identification and reporting of environmental hazards. **3. Monitoring and Quality Assurance:** ◦ The Administrator or designee will perform weekly walk-through inspections of the premises (interior and exterior) for the next 3 months, with documented findings and immediate corrective actions taken as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2726	A. BUILDING _____ B. WING _____	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMELA HOMES	**5500 CLEARY COURT, LAS VEGAS, NEVADA ,89109**

(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
	Findings Include: On 09/04/25 in the morning, the following observations were made in the backyard of the facility: - Rusted double seated glider with deteriorated fabric and exposed seating brackets and hardware. - Exposed brown metal hospital bed frame. - Twin-size stainless-steel metal bed frame. - Black metal bed frame. - Metal dining/patio table frame. - Ladder. - Empty bird cage. - Corrugated roofing debris - Two Dried paint roller trays - Paint roller extension pole - Weathered wooden patio/dining table - A pile of old wood cuttings and refuse debris along perimeter fence - A dead log obstructing side concrete walkway - Uneven concrete slab on rear walkway On 09/04/25 in the morning, the following observations were made in the kitchen and living room of the care facility: - Vents in the living room/dining area had thick layer of dust. - Hanging lamp and vent had thick layer of dust in the kitchen.		◦ Results of inspections will be reviewed during the facility's monthly. ◦ After 3 months, inspections will transition to monthly and continue to be monitored. **4. The owner or the facility administrator will be responsible for ensuring the plan of correction is implemented.** **5. All immediate corrective actions were completed on 9/30/2025.** **6. Please see attached photo documentation for corrected action plan.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2726	A. BUILDING _____ B. WING _____	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMELA HOMES	**5500 CLEARY COURT, LAS VEGAS, NEVADA ,89109**

(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
	On 09/4/25 in the morning, the Administrator acknowledged the premises had not been well maintained and the above-mentioned areas in the kitchen, living room/dining area, and items in the backyard of the facility needed to be cleaned up.			
Y 1800 SS= F	NAC 449.01065 Requirements relating to personal protective equipment; exception for nursing pool. (NRS 439.200, 439.0302) 1. A medical facility, facility for the dependent or other facility required by the regulations adopted by the Board pursuant to NRS 449.0303 to be licensed shall ensure that each person on the premises of the facility uses personal protective equipment in accordance with the publications adopted by reference in NAC 449.0106. The facility shall maintain: (a) Not less than a 30-day supply of personal protective equipment at all times; or (b) If the facility is unable to comply with the requirements of paragraph (a) due to a shortage in personal protective equipment, documentation of attempts by and the inability of the facility to obtain personal protective equipment. 2. Except as otherwise provided in subsection 3, a medical facility, facility for the dependent or other facility required by the regulations adopted by the Board pursuant to NRS 449.0303 to be licensed shall: (a) Enter into a contract with a supplier of personal protective equipment which ensures that the facility has a supply of personal protective equipment sufficient to comply with the requirements of subsection 1; and (b) Track the amount of personal protective equipment that the facility has available, the rate at which personal protective equipment is used in the facility and orders for personal protective equipment in a manner sufficient to ensure	Y 1800	**1. Corrective Actions Taken** As of **9/30/2025** the following corrective actions have been completed: • The facility **replenished its PPE stock** to meet and exceed the 30-day minimum requirement, including: ◦ Gloves (latex and non-latex) ◦ Surgical masks ◦ Disposable gowns ◦ Face shields/goggles ◦ Hand sanitizer and disinfectant (supportive infection control supplies) **2. Systemic Changes to Prevent Recurrence** To ensure continuous compliance with PPE regulations, the following systemic changes have been implemented: • The tracking system was created as of 9/30/2025, which includes: ◦ Inventory logs updated weekly ◦ Order history and delivery documentation • The facility now conducts **monthly audits** of PPE inventory levels and usage trends, with results documented and kept on file. **3. Monitoring and Quality Assurance**	09/30/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2726	A. BUILDING _____ B. WING _____	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMELA HOMES	**5500 CLEARY COURT, LAS VEGAS, NEVADA ,89109**

(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
	compliance with the requirements of subsection 1. Inspector Comments: Based on observation and interview, the agency failed to ensure there was a 30-day supply of personal protective equipment. Findings include: On 09/04/25 in the morning, the facility had 1 open box of gloves, 1 box of masks, and 4 disposable gowns on site at the time of survey. On 09/04/25, in the morning, the Administrator acknowledged the agency did not have a 30-day supply of PPE available on site.		• The **Administrator or designee** will perform **weekly PPE inventory audits** to ensure minimum stock levels are maintained at or above the 30-day requirement. • PPE availability, usage, and supplier reliability will be reviewed every month by owner or facility administrator. **4. The owner or facility administrator are responsible for ensuring the plan of correction is implemented.** **5. Completion Date of Corrective Actions** All corrective actions were completed by 9/30/2025.	
Y 1700 SS= D	**NRS 449.1845** **Administrator of residential facility for groups to conduct annual assessment of history of each resident and cause provider of health care to conduct certain examinations and assessments; placement based on assessment.** 1. The administrator of a residential facility for groups shall: (a) Annually cause a qualified provider of health care to conduct a physical examination of each resident of the facility; (b) Annually conduct an	Y 1700	1. Corrective Actions Taken • A Physician Placement Determination for R3 was not yet completed at this time as resident is currently in the hospital. A physician Placement determination will be obtained by a licensed	09/30/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2726	A. BUILDING _____ B. WING _____	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMELA HOMES	5500 CLEARY COURT, LAS VEGAS, NEVADA ,89109

(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
	assessment of the history of each resident of the facility, which must include, without limitation, an assessment of the condition and daily activities of the resident during the immediately preceding year; and (c) Cause a qualified provider of health care to conduct an assessment of the condition and needs of a resident of the facility to determine whether the resident meets the criteria prescribed in paragraph (a) of subsection 2: (1) Upon admission of the resident to the facility; and (2) If a physical examination, assessment of the history of the resident or the observations of the administrator or staff of the facility, the family of the resident or another person who has a relationship with the resident indicate that: (I) The resident may meet those criteria; or (II) The condition of the resident has significantly changed. 2. If, as a result of an assessment conducted pursuant to paragraph (c) of subsection 1, the provider of health care determines that the resident: (a) Suffers from dementia to an extent that the resident may be a danger to himself or herself or others if the resident is not		healthcare provider before resident will be admitted back to the group home facility, and placed in the resident's file. • R3's care plan will be reviewed and updated in accordance with the physician's recommendations regarding cognitive condition, supervision needs, and safety. • A 100% audit of all current resident files was completed on 9/30/2025 to ensure all required assessments are present and up to date. Any missing assessments were immediately addressed. 2. Systemic Changes to Prevent Recurrence To prevent recurrence, the following systemic changes have been made effective 9/30/2025: • The facility's Admission	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2726	A. BUILDING _____ B. WING _____	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMELA HOMES	5500 CLEARY COURT, LAS VEGAS, NEVADA ,89109

(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
	placed in a secure unit or a facility that assigns not less than one staff member for every six residents, any residential facility for groups in which the resident is placed must meet the requirements prescribed by the Board pursuant to subsection 2 of NRS 449.0302 for the licensing and operation of residential facilities for groups which provide care to persons with Alzheimer's disease or other severe dementia. (b) Does not suffer from dementia as described in paragraph (a), the resident may be placed in any residential facility for groups. 3. As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031. (Added to NRS by 2019, 2594) Inspector Comments: Based on interview and record review, the facility failed to obtain a Physician Placement Determination upon admission for 1 of 5 residents (Resident #3). Findings include: Resident #3 (R3) R3 was admitted to the facility on 06/18/25, with diagnoses including anoxic brain damage and hypertension.		Policy and Procedure was updated to require: ◦ A physician placement determination or equivalent assessment by a qualified healthcare provider prior to or upon admission, as required by regulation. • A new Resident Admission Checklist was implemented and must be signed by the Administrator before admission is finalized. ◦ The checklist includes: physician placement form, physical exam, social history, cognitive assessment (if applicable), and documentation of supervision needs. • Staff responsible for the admission process were retrained on 09/15/25 on: ◦ NRS 449.0302 assessment requirements	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2726	A. BUILDING _____ B. WING _____	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMELA HOMES	**5500 CLEARY COURT, LAS VEGAS, NEVADA ,89109**

(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
	R3's file lacked a Physician Placement Determination form. A County Social Services Assessment dated 04/30/25 documented R3 had memory loss and cognitive decline. R3's mental status was described as forgetful and confused. R3 was documented as needing supervision due to wandering and being a fall risk. On 09/04/25 in the morning, R3 was unable to determine the day of the week or the current year. On 09/04/25 in the morning, the Owner acknowledged a Physician Placement Determination was not obtained for R3.		◦ The definition and role of a qualified provider of health care (per NRS 629.031) ◦ Ensuring appropriate placement based on healthcare assessments 3. Monitoring and Quality Assurance To ensure ongoing compliance: • The Administrator or designee will conduct monthly audits of all new admissions to ensure: ◦ A provider's placement determination form is completed and filed. ◦ All care plans reflect any supervision or dementia-related needs identified by the provider. • Findings will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2726	A. BUILDING _____ B. WING _____	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMELA HOMES	**5500 CLEARY COURT, LAS VEGAS, NEVADA ,89109**

(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
			documented and reviewed in monthly. • The administrator will also review any resident condition changes to ensure reassessments are obtained when required under NRS 449.0302(1)(c). 4. The owner or facility administrator are responsible for ensuring the plan of correction is implemented. 5. Completion Date of Corrective Actions All corrective actions were completed by 9/30/2025	