

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 6/15/2026
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/27/2021
NAME OF PROVIDER OR SUPPLIER SANTA FE CARE HOME I			STREET ADDRESS, CITY, STATE, ZIP CODE 4621 EXPOSITION AVE, LAS VEGAS, NEVADA ,89102	
(X4) ID PREFIX TAG 0000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG 0000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation conducted at your facility on 12/27/21, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility was licensed for ten Residential Facility for persons with elderly and disabled and/or chronic illness and/or persons with mental illness, five Category I and five Category II residents. The sample size was two. The facility received a grade of A. One complaint was investigated. Complaint #NV00065100 with one allegation was unsubstantiated. Allegation #1 - The facility discharged a resident requiring care to a facility without a license to provide care could not be substantiated based on interviews with a Caregiver, the Owner, and the Administrator who reported the resident was independent and able to care for themselves. Review of a document signed by the resident of concern stated they were choosing to discharge to the facility without a license. A review of a physician's statement indicating the resident was able to provide for their own care without assistance. The investigation into the allegation included: Interviews with a Caregiver, the Owner, and the Administrator. Documentation review of the facility's discharge policy. Record review of two discharged resident files, review of physician statements and discharge forms signed by a resident. The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. There were no regulatory deficiencies identified. No further action necessary. Please retain a copy for your records.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER Name:
REPRESENTATIVE'S SIGNATURE

Title:

Date:

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.