STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8675	A. BUILDING _____ B. WING _____	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMEERY CARE	333 PRINCE GEORGE ROAD, LAS VEGAS, NEVADA ,89123

(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		

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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 conducted at your facility on 12/04/25, in accordance with Nevada Administrative Code, Chapter 449, Residential Facilities for Groups. The facility is licensed for ten Residential Facility for Group beds for elderly and disabled persons and/or persons with Alzheimer's disease, Category II residents. The census at the time of the survey was eight. Eight resident files and five employee files were reviewed. The facility received a grade of B.			
Y 0515 SS= E	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: (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,	Y 0515	1. Administrator and staff immediately updated person centered care plans of said residents. 2. Administrator came up with an audit list of all the items that a resident's file should have. 3. Administrator and owner will regularly check resident files for completion and compliance. 4. Administrator will make sure that POC is implemented. 5. Completed on Dec. 4, 2025	12/04/2025

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	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 interview and record review, the facility failed to ensure an initial and annual person-centered care plan was completed annually for 4 of 8 residents (Resident #1, #2, #3 and #4). Findings include: Resident #1 (R1) R1 was admitted on 10/23/23 with diagnosis including traumatic brain injury.			

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	R1's file revealed a person-centered care plan was last completed on 03/11/24. There was no documentation a person-centered care plan was completed annually for R1. Resident #2 (R2) R2 was admitted on 03/01/22 with diagnosis including senile degeneration of the brain. R2's file revealed a person-centered care plan was last completed on 04/09/24. There was no documentation a person-centered care plan was completed annually for R2. Resident #3 (R3) R3 was admitted on 09/01/23 with diagnosis including Alzheimer's disease. R3's file revealed a person-centered care plan was last completed on 04/09/24. There was no documentation a person-centered care plan was completed annually for R3. Resident #4 (R4) R4 was admitted on 07/12/25 with diagnosis including obesity and chronic pain. R4's file lacked documented evidence an initial person-centered care plan was completed. On 12/04/25 at 11:00 AM, the Owner confirmed an initial person-centered care plan had not been completed for R4 and was not aware an annual person-centered care plan was required and unable to provide documentation for R1, R2, and R3. Severity: 2 Scope: 2			
Y 0874 SS= F	**NAC 449.2742** **Administration of medication: Responsibilities of administrator, caregiver and employees of facility.**	Y 0874	1. Administrator signed said medication reviews. 2. Administrator came up with an audit list of all the items that a resident's file should have. 3. Administrator and owner will regularly check resident files for completion and compliance. 4. Administrator will make sure that POC is	12/04/2025

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	2. Within 72 hours after the administrator of the facility receives a report submitted pursuant to paragraph (a) of subsection 1, a member of the staff of the facility shall notify the resident's physician of any concerns noted by the person who submitted the report. The report must be reviewed and initialed by the administrator. Inspector Comments: Based on interview and record review, the Administrator failed to review the six-month medication reviews within 72 hours of completion, for 5 of 8 residents (Resident #1, #2, #4, #5, and #7). Findings include: Resident #1 (R1) R1 was admitted on 10/23/23, with diagnosis including traumatic brain injury. Review of R1's file revealed a medication review was completed on 06/08/25; however, was not reviewed and signed off by the Administrator. Resident #2 (R2) R2 was admitted on 03/01/22, with diagnosis including senile degeneration of the brain. Review of R2's file revealed a medication review was completed on 06/22/25; however, was not reviewed and signed off by the Administrator. Resident #4 (R4) R4 was admitted on 07/12/25, with diagnosis including obesity and chronic pain. Review of R4's file revealed a medication review was completed on 10/25/25;		implemented. 5. Completed on Dec. 04, 2025. 6. Please see attachments.	

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	however, was not reviewed and signed off by the Administrator. Resident #5 (R5) R5 was admitted on 08/26/25, with diagnosis including dementia. Review of R5's file revealed a medication review was completed on 10/25/25; however, was not reviewed and signed off by the Administrator. Resident #7 (R7) R7 was admitted on 08/21/25, with diagnosis including dementia. Review of R7's file revealed a medication review was completed on 05/13/25; however, was not reviewed and signed off by the Administrator. On 12/04/25 at 11:00 AM, the Administrator confirmed the medication reviews were not signed and should have been. Severity: 2 Scope: 3			

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Y 1840	**R063-21 Sec. 4.** Sec. 4. 1. An unlicensed caregiver who provides care to residents, patients or clients at a facility described in section 3 of this regulation shall annually complete evidence-based training provided by a nationally recognized organization concerning the control of infectious diseases. The training must include, without limitation, instruction concerning: (a) Hand hygiene; (b) The use of personal protective equipment, including, without limitation, masks, respirators, eye protection, gowns and gloves; (c) Environmental cleaning and disinfection; (d) The goals of infection control; (e) A review of how pathogens, including, without limitation, viruses, spread; and (f) The use of source control to prevent pathogens from spreading. 2. Each unlicensed caregiver who completes the training required by subsection 1 must provide proof of completion of that training to the administrator or other person in charge of the facility in which the unlicensed caregiver provides care.	Y 1840	1. Administrator requested said employees to take their training. 2. Administrator came up with an audit list of all the items that an employee's file should have. 3. Administrator and owner will regularly check employee files for completion and compliance. 4. Administrator will make sure that POC is implemented. 5. Completed on 12/16/2025. 6. Please see attachments.	12/16/2025
Y 1600 SS= F	**NAC 449.011943 and R004-24** **NAC 449.011943 Policies concerning preferred names and pronouns; adaptation of records to reflect gender identities or expressions; method to obtain medically relevant information from patients or residents. (NRS 449.0302, 449.104)** 1. A facility shall: (a) Develop policies to ensure that a patient or resident is addressed by his or her preferred	Y 1600	1. Administrator came up with a form to document residents gender identity, preferred pronoun and sexual orientation. 2. Administrator came up with an audit list of all the items that a resident's file should have. 3. Administrator and owner will regularly check resident files for completion and compliance. 4. Administrator will make sure that POC is implemented. 5. Completed on Dec. 6, 2025. 6. Please see attachment.	12/06/2025

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	name and pronoun and in accordance with his or her gender identity or expression; and (b) To the extent practicable and available within the systems in use at the facility: (1)Adapt electronic records and any paper records the facility uses to reflect the preferred name, pronoun and gender identity or expression of a patient or resident; and (2) Integrate information concerning gender identity or expression into electronic systems for maintaining health records. 2. If a patient or resident chooses to provide the following information, the records adapted pursuant to subparagraph (1) of paragraph (b) of subsection 1 must to the extent required by subsection1, include, without limitation: (a) The preferred name and pronoun ofthe patient or resident; (b) The gender identity or expressionof the patient or resident; (c) The gender identity or			

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	expression of the patient or resident that was assigned at the birth of the patient or resident; (d) The sexual orientation of the patient or resident; and (e) If the gender identity or expression of the patient or resident is different than the gender identity or expression of the patient or resident that was assigned at the birth of the patient or resident: (1) A history of the gender transition and current anatomy of the patient or resident; and (2) An organ inventory for the patient or resident which includes, without limitation, the organs: (I) Present or expected to be present at the birth of the patient or resident; (II) Hormonally enhanced or developed in the patient or resident; and (III) Surgically removed, enhanced, altered or constructed in the patient or resident. Inspector Comments: Based on interview and record review, the facility failed to develop a form and policy to document residents gender identity, preferred pronoun and sexual orientation for 8 of 8 residents.			

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	Findings include: On 12/04/25 in the morning, a review of resident files revealed the facility did not document residents gender identity, preferred pronoun or sexual orientation. On 12/04/25 in the morning, the Owner confirmed they did not have a system in place to document residents gender identity, preferred pronoun or sexual orientation. Severity: 2 Scope: 3			
Y 1540 SS= D	**NAC 449.011931and R004-24** NAC 449.011931 Cultural competency training for agent or employee who provides care to patient or resident. (NRS 449.0302, 449.103) 1. Except as otherwise provided in NRS 449.103, as amended by section 1 of Assembly Bill No. 267, chapter 202, Statutes of Nevada 2023, at page 1176, a facility shall provide cultural competency training through an approved course or program to an agent or employee described in subsection 2 of NRS 449.103, as amended by section 1 of Assembly Bill No. 267, chapter 202, Statutes of Nevada 2023, at page 1176: (a) Within 90 days after contracting with or hiring the agent or employee; (b) At least biennially thereafter. Such biennial training must consist of at least 2 hours of instruction each biennium. 2. The facility may provide the training required by subsection 1 over several instructional periods or during a single instructional period so long as the agent or employee: (a) Completes the hours of cultural competency training required by subsection 1 and the entire contents of the course or program; and (b) Receives a certificate of completion on or before the date on which subsection 1 requires the agent or employee to complete the cultural competency training. 3. Except as otherwise provided in	Y 1540	1. Administrator requested said employee to take the cultural competency training. 2. Administrator came up with an audit list of all the items that an employee's file should have. 3. Administrator and owner will regularly check employee files for completion and compliance. 4. Administrator will make sure that POC is implemented. 5. Completed on Dec. 11, 2025. 6. Please see attachment.	12/11/2025

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	subsection 4, the facility shall keep documentation in the personnel file of an agent or employee of the facility or a record of an agent or employee in the relevant electronic system of the facility proof of the completion of the cultural competency training required pursuant to NRS 449.103, as amended by section 1 of Assembly Bill No. 267, chapter 202, Statutes of Nevada 2023, at page 1176. 4. If an agent or employee of a facility is exempt from the requirement to complete cultural competency training pursuant to subsection 3 of NRS 449.103, as amended by section 1 of Assembly Bill No. 267, chapter 202, Statutes of Nevada 2023, at page 1176, the facility shall maintain proof in the personnel file of the agent or employee or a record of the agent or employee in the relevant electronic system of the facility that the agent or employee holds a valid professional license, registration or certificate, as applicable, for which the continuing education described in subsection 3 of NRS 449.103, as amended by section 1 of Assembly Bill No. 267, chapter 202, Statutes of Nevada 2023, at page 1176, is required for renewal. Inspector Comments: Based on interview and record review the facility failed to ensure Cultural Competency training was completed within 30 days of hire for 1 of 5 employees (Employee #4). Findings include: Employee #4 (E4) was hired on 03/04/25 as a Caregiver. E4's employee file lacked documented evidence Cultural Competency training had been completed within 30 days of hire. On 12/04/25 at 10:45 AM, a Caregiver acknowledged E4 had not completed Cultural Competency training. Severity: 2 Scope : 1			

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