

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8675	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/01/2026
NAME OF PROVIDER OR SUPPLIER AMEERY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 333 PRINCE GEORGE ROAD, LAS VEGAS, NEVADA ,89123		
(X4) ID PREFIX TAG RFG 0000- No Deficiencies	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	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
	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 completed in your facility on 04/01/26. The census at the time of the survey was ten. The sample size was six. The facility received a grade of A. There was one complaint investigated. Unsubstantiated: 1. Complaint #13185 could not be substantiated. No regulatory deficiencies could be identified. The investigation of the complaint included: Observations of residents, facility visitors, staff interacting with residents, residents receiving care, resident activities, meal preparation, medication administration and a tour of the facility. Interviews were conducted with residents, a Cook, a Medication Technician, the hospice Clinical Coordinator and the Owner.			

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
REPRESENTATIVE'S SIGNATURE Name:

Title:

Date:

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	Clinical Record Review of six records. Document Review included the facility menu, the facility activity schedule and facility policy and procedures.				