STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9131	A. BUILDING _____ B. WING _____	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE AT CHEYENNE	6031 W. CHEYENNE AVENUE, LAS VEGAS, NEVADA ,89108

(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
	9131	A. BUILDING _____ B. WING _____	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE AT CHEYENNE	6031 W. CHEYENNE AVENUE, LAS VEGAS, NEVADA ,89108

(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 completed at your facility on 03/03/26. The facility is licensed for ten Residential Facility for Group beds for elderly and disabled persons and/or Mental Illness, Category II residents. The census at the time of the survey was eight. 25 resident files and 10 employee files were reviewed. The facility received a grade of A. The sample size was five including the Resident of Concern (ROC).			
Y 0255 SS= F	NAC 449.217 6. A residential facility with **more than 10 residents** must: (a) Comply with the standards prescribed in chapter 446 of NAC; and (b) Obtain the necessary permits from	Y 0255	Dinning Services Director(Executive Chef) has trained and will all kitchen staff on how to properly store raw meat in the walk in cooler. DSD will monitor walk in fridge on a regular basis to ensure proper storage is being uses. Please see the attached phot of the new poster that is on the walk in fridge. * Please see attached picture. Plant Operations Director has fixed the hot water for the hand washing sink next to the	03/06/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9131	A. BUILDING _____ B. WING _____	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE AT CHEYENNE	6031 W. CHEYENNE AVENUE, LAS VEGAS, NEVADA ,89108

(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
	the Division. 7. The equipment used for cooking and storing food and for washing dishes in a residential facility with more than 10 residents must be inspected and approved by the Division and the state and local fire safety authorities. Inspector Comments: Based on observation on 03/03/2026, the facility failed to ensure the kitchen and supportive dining services complied with the standards of NAC 446. Findings include: 1. Critical Violations: a. In the walk-in cooler, raw chicken was stored over raw trout on a speed rack. b. There was no hot water available at the hand washing sink next to the ice cream freezer. 2. Major Violations: a. The cook's line ventilation filters above the deep fat fryer were soiled with grease build-up. 3. Equipment and Maintenance Violations: a. The drain line from the dish machine was setting in the basin below the flood rim of the floor sink. Severity: 2 Scope: 3		ice cream freezer. Plant Ops director will monitor the water temps on a regular basis to ensure the water meets the requirements for hot water. We have a scheduled cleaning service that comes every 90 days to clean ventilation filters in the kitchen. Dinning services Director and Plant ops director with insure that every 90 days this services is completed and if needed, to call the service company out sooner to complete task. *Please see attached pictures. Plant ops came and fixed the drain to ensure it was sitting below the flood rim of the floor sink. Plant ops will continue to monitor the drain to ensure the drain pipe continues to sit below the flood rim of the floor. Please see attached picture,	
Y 0786 SS= D	**NAC 449.2726(rev. by LCB 109-18 (22) and R043-22** 2. A caregiver employed by a residential facility may assist a	Y 0786	The Administrator and/or designee will audit every resident's room who uses needles daily to ensure that there is a sharps container available. The Administrator and/or designee will monitor the "fullness" of each container weekly and will supply new empty sharps	03/04/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9131	A. BUILDING _____ B. WING _____	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE AT CHEYENNE	6031 W. CHEYENNE AVENUE, LAS VEGAS, NEVADA ,89108

(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
	resident in the administration of the medication prescribed to the resident for his or her diabetes if: (d) The medication prescribed to the resident for his or her diabetes is not administered by injection or intravenously or is administered using an auto-injection device in accordance with the requirements of NRS 449.0304 and section 13 of this regulation. (of LCB File No. R109 -18). (e) The caregiver has successfully completed training and examination approved by the Division pursuant to section 12 of this regulation regarding the administration of such medication. 3. The caregivers employed by a residential facility with a resident who has diabetes shall ensure that: (a) Sufficient amounts of medicines, equipment to perform tests, syringes, needles and other supplies are maintained and stored in a secure place in the facility; (b) Syringes and needles are disposed of appropriately in a sharps container which is stored in a safe place; and (c) The caregivers responsible for the resident have received instruction in the recognition of the symptoms of hypoglycemia and hyperglycemia by a medical		containers as needed. The Administrator and/or designee will monitor the "fullness" of each container weekly and will supply new empty sharps containers as needed. The administrator will ensure that this plan is implemented	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9131	A. BUILDING _____ B. WING _____	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE AT CHEYENNE	6031 W. CHEYENNE AVENUE, LAS VEGAS, NEVADA ,89108

(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
	professional who has been trained in the recognition of those symptoms. Inspector Comments: Based on observation and interview, the facility failed to provide a sharps container to a resident who used needles daily to check blood sugars, for 1 of 25 residents (Resident #8). Findings include: Resident #8 (R8) was admitted on 04/30/25 with diagnosis including type 2 diabetes mellitus and hypertension. On 03/03/26 in the morning, around 100 used blood sugar testing needles were found stacked in a container used to bring food to R8's room. On 03/03/26 in the morning, R8 indicated the facility did not provider a sharps container so they just stacked the used needles in whatever was available for use, until staff came and removed the needles. On 03/03/26 in the morning, a Medication Technician confirmed the facility had not provided R8 a sharps container to properly dispose of R8's used needles. Severity: 2 Scope: 1			
Y 0870 SS= E	NAC 449.2742 **Administration of medication: Responsibilities of administrator, caregiver and employees of facility.** 1. The administrator of a residential facility that provides assistance to residents in the	Y 0870	The Administrator and/or designee will audit every resident's chart to ensure that there is a med review completed. The administrator and/or designee will monitor each resident's chart monthly to ensure that med review is completed. The administrator will ensure that this plan is implemented.	03/04/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9131	A. BUILDING _____ B. WING _____	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE AT CHEYENNE	6031 W. CHEYENNE AVENUE, LAS VEGAS, NEVADA ,89108

(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
	administration of medications shall: (a) Ensure that a physician, pharmacist or registered nurse who does not have a financial interest in the facility: (1) Reviews for accuracy and appropriateness, at least once every 6 months the regimen of drugs taken by each resident of the facility, including, without limitation, any over-the-counter medications and dietary supplements taken by a resident; and (2) Provides a written report of that review to the administrator of the facility. (b) Include a copy of each report submitted to the administrator pursuant to paragraph (a) in the file maintained pursuant to NAC 449.2749 for the resident who is the subject of the report. (c) Make and maintain a report of any actions that are taken by the caregivers employed by the facility in response to a report submitted pursuant to paragraph (a). Inspector Comments: Based on record review and interview, the facility failed to ensure a medication review was completed every six months for 12 of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9131	A. BUILDING _____ B. WING _____	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE AT CHEYENNE	**6031 W. CHEYENNE AVENUE, LAS VEGAS, NEVADA ,89108**

(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
	25 sampled residents (Resident #1, #2, #5, #6, #7, #11, #12, #14, #16, #18, #19, and #22). Findings include: Resident #1 (R1) R1 was admitted on 11/16/24 with diagnoses including Parkinson's Disease and hypertension. R1's file lacked documented evidence of six-month medication reviews completed within the past year. Resident #2 (R2) R2 was admitted on 11/25/24 with diagnoses including atrial fibrillation and hypertension. R2's file lacked documented evidence of six-month medication reviews completed within the past year. Resident #5 (R5) R5 was admitted on 04/27/24 with diagnoses including dementia and hypertension. R5's file lacked documented evidence of six-month medication reviews completed within the past year. Resident #6 (R6) R6 was admitted on 09/22/20 with diagnoses including osteoporosis and hyperlipidemia.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9131	A. BUILDING _____ B. WING _____	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE AT CHEYENNE	**6031 W. CHEYENNE AVENUE, LAS VEGAS, NEVADA ,89108**

(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
	R6's file lacked documented evidence of six-month medication reviews completed within the past year. Resident #7 (R7) R7 was admitted on 05/30/23 with diagnoses including restless leg syndrome and insomnia. R7's file lacked documented evidence of six-month medication reviews completed within the past year. Resident #11 (R11) R11 was admitted on 06/26/25 with diagnoses including diabetes and hypertension. R11's file lacked documented evidence of six-month medication reviews completed within the past year. Resident #12 (R12) R12 was admitted on 02/25/25 with diagnoses including dementia and hypertension. R12's file lacked documented evidence of six-month medication reviews completed within the past year. Resident #14 (R14) R14 was admitted on 12/16/21 with diagnoses including Parkinson’s Disease and hypertension.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9131	A. BUILDING _____ B. WING _____	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE AT CHEYENNE	**6031 W. CHEYENNE AVENUE, LAS VEGAS, NEVADA ,89108**

(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
	R14's file lacked documented evidence of six-month medication reviews completed within the past year. Resident #16 (R16) R16 was admitted on 05/66/19 with diagnoses including mild obesity and dehydration. R16's file lacked documented evidence of six-month medication reviews completed within the past year. Resident #18 (R18) R18 was admitted on 04/29/25 with diagnoses including Parkinson's Disease and hypertension. R18's file lacked documented evidence of six-month medication reviews completed within the past year. Resident #19 (R19) R19 was admitted on 03/22/24 with diagnoses including Parkinson's Disease and hypertension. R19's file lacked documented evidence of six-month medication reviews completed within the past year. Resident #22 (R22) R22 was admitted on 10/23/24 with diagnoses including Parkinson's hypertension. R22's file lacked documented evidence of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9131	A. BUILDING _____ B. WING _____	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE AT CHEYENNE	6031 W. CHEYENNE AVENUE, LAS VEGAS, NEVADA ,89108

(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
	six-month medication reviews completed within the past year. On 03/03/26 in the morning, the Director of Health Services verbalized the facility was working with a new pharmacy to complete required six-month medication reviews, as the previous pharmacy was not completing the medication reviews every six-months as required. On 03/03/26 in the morning, the Director of Health Services acknowledged six-month medication reviews were not completed for sampled Residents #1, #2, #5, #6, #7, #11, #12, #14, #16, #18, #19, and #22. Severity: 2 Scope: 2			
Y 0557 SS= D	**NAC 449.262 and R043-22** **Provisions of dental, optical and hearing care and social services; report of suspected abuse, neglect or exploitation; restriction on use of restraints, confinement or sedatives.** 3. The members of the staff of a residential facility shall not: (a) Use restraints on any resident; (b) Lock a resident in a room inside the facility; or (c) Provide sedatives to a resident unless that sedative has been prescribed for that resident by a physician, physician assistant or advanced practice registered nurse to treat specific symptoms. A caregiver shall make a record of the behavior of a resident who has been prescribed a sedative.	Y 0557	The administrator and/or designee will audit every resident who uses a side rails to see if they would prefer a half rail. If yes, the administrator and/or designee will then asses to see if resident can demonstrate the proper use of the half rail. Anytime a resident receives a hospital bed, the administrator and/or designee will ensure no restraints will be added to the residents bed. **This resident passed away on 4/14/26, while on hospice.	04/22/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9131	A. BUILDING _____ B. WING _____	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE AT CHEYENNE	**6031 W. CHEYENNE AVENUE, LAS VEGAS, NEVADA ,89108**

(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
	Inspector Comments: Based on observation and interview, the facility failed to ensure bed rails were not in use for 1 of 25 residents (Resident #11). Findings include: Resident #11 (R11) was admitted on 06/26/25 with diagnosis including type 2 diabetes mellitus and hypertension. On 03/03/26 in the morning, R11 was found in bed with a single full bed rail in the up position on both sides of the bed. R11 was unable to demonstrate the ability to move the bed rails up or down. On 03/03/26 in the morning, a Wellness Nurse confirmed R11 had a full bed rail in the up position, R11 could not move the bed rails up or down, and it should not be in use. Severity: 2 Scope: 1			