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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**08/07/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALZHEIMERS LUXURY CARE	**2951 VIKING ROAD, LAS VEGAS, NEVADA ,89121**

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation survey completed at your facility on 08/07/25, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility 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 ten. Ten resident files and three employee files were reviewed. The facility received a grade of C. There was one complaint investigated. Substantiated: 1, Complaint #NV00074346 was substantiated. (See TAGs Y0053 and Y1010) The investigation of the complaint included: Observation of residents, including residents of concern, and facility exit doors. Interviews conducted with residents, including residents of concern, and Caregivers. Clinical record review of 10 resident records, including residents of concern and employee records. The findings and conclusions of any investigation by the Division of Health Care Purchasing and Compliance 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. The following regulatory deficiencies were identified:	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: EMELITA TUGAS Title: Administrator Date: 02/14/2026

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.

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0050 SS= F	Administrator's Responsibilities - Oversight - NAC 449.194 Responsibilities of administrator. (NRS 449.0302) The administrator of a residential facility shall: 1. Provide oversight and direction for the members of the staff of the facility as necessary to ensure that residents receive needed services and protective supervision and that the facility is in compliance with the requirements of NAC 449.156 to 449.27706, inclusive, and chapter 449 of NRS. Inspector Comments: Based on observation, record review and interview, the Administrator failed to provide oversight and supervision to ensure the facility was in compliance with the requirements of NAC 449.156 to 449.27706 inclusive, and chapter of 449 of NRS. Findings include: The following TAGs were cited in this Statement of Deficiency (SOD) and lacked oversight by the Administrator. (Y0053) Failed to ensure resident records were onsite, complete and accurate. (Y1010) Failed to ensure the facility had a mental illness endorsement to provide services to and care for residents with mental illnesses. Severity: 2 Scope: 3	0050	As of December 30, 2025, a new adminitrator has been assigned and is actively serving as the **Administrator** of the residential facility. The Administrator has assumed full responsibility for oversight and direction of facility staff to ensure residents receive required services, appropriate protective supervision, and that the facility operates in compliance with **NAC 449.156–449.27706** and **NRS Chapter 449**.	01/19/2026
0053 SS= F	Administrator's Responsibilities-Complete Rec - NAC 449.194 Responsibilities of administrator. (NRS 449.0302) The administrator of a residential facility shall: 4. Ensure that the records of the facility are complete and accurate. Inspector Comments: Based on record review and interview, the facility failed to ensure records were complete and onsite for 6 of 10 residents (Resident #1, #2, #3, #4, #7, and #8); and 3 of 3 employees. (Employee #1, #2 and #3) Findings include: Resident #1 (R1) R1 was admitted on 05/25/25 with primary diagnoses of dementia, hypertension and diverticulosis. R1's record lacked documented evidence of a transfer document to provide information on where the resident transferred from and	0053	**As of January 19, 2026,** a new administrator has been appointed as the Administrator of the facility. The Administrator has assumed responsibility for ensuring that all facility records are complete, accurate, current, and properly maintainedin accordance with NAC 449 and NRS Chapter 449. Measures to Prevent Recurrence • The Administrator will review all required facility documentation, including: ◦ Resident records ◦ Staff files and training records ◦ Incident and accident reports ◦ Medication administration records (if applicable)	01/20/2026

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	other information. Resident #2 (R2) R2's record lacked documented evidence of an admit date, diagnoses, a physical exam and placement determination. R2's record lacked documented evidence of a transfer document to provide information on where the resident transferred from and other information. Resident #3 (R3) R3's record lacked documented evidence of an admit date, date of birth, Activities of Daily Living (ADL) assessment, diagnoses, Ultimate User Agreement (UUA), a physical exam and placement determination. R3's record lacked documented evidence of a transfer document to provide information on where the resident transferred from and other information. Resident #4 (R4) R4's record lacked documented evidence of an admit date, date of birth, ADL Assessment, UUA, a physical exam or placement determination. R4's record documented diagnoses of schizophrenia, bipolar disorder and dementia. R4's record lacked documented evidence of a transfer document that provided information on the date of the transfer, where the resident transferred from and other information. Resident #7 (R7) R7's record lacked documented evidence of an admit date, UUA, a physical exam and placement determination. R7's diagnoses included Parkinson's disease, atherosclerosis of coronary arteries. Resident #8 (R8) R8 was admitted on 05/22/25 with primary diagnoses including atherosclerosis of coronary arteries a pacemaker and Type II diabetes. R8's record lacked documented evidence of a placement determination and ADL Assessment. R8's record lacked documented evidence of a transfer document that provided information on the date of the transfer, where the resident transferred from and other information. Employee #1 (E1) E1 was hired on 10/14/24 as a Caregiver. E1's record documented annual Medication Management training dated 07/05/24. E1's record lacked documented evidence of a		• Policies and procedures related to documentation and recordkeeping will be reviewed with staff. • Staff will be instructed and re-educated on proper documentation practices, including timely, accurate, and complete record entries. • Documentation requirements will be incorporated into ongoing staff supervision. Monitoring System • The Administrator will conduct routine audits of facility records to verify accuracy and completeness. • Any identified documentation deficiencies will be corrected promptly and addressed with staff through retraining or corrective action as needed. • Ongoing compliance will be monitored to ensure continued adherence to regulatory requirements. Responsible Party Administrator Date of Compliance January 19, 2026	

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	2025 training renewal. E1's record lacked documented evidence of a NABS Clearance Letter. Employee #2 (E2) E2 was hired on 05/22/25 as a Caregiver. E2's record lacked documented evidence of a physical examination. E2's record documented a one step TB test with an inject date of 03/05/24 and result on 03/07/24 with a negative result. E2's record lacked documented evidence of a second step TB test and a 2025 annual TB test. E2's record lacked documented evidence of the initial 16-hour Medication Management training. It was noted in E2's record that the 16 hours training was needed. E2's record lacked documented evidence of a NABS Clearance Letter. Employee #3 (E3) E3 was hired on 11/13/24 as a Caregiver. E3's record documented a two-step TB test with a final read date of 07/23/24. E3's record lacked documented evidence of an annual 2025 TB test. It was noted in E3's record that the 2025 renewal was needed. E3's record lacked documented evidence of fingerprinting and a NABS Clearance Letter. The Nevada Automated Background Check System (NABS) was not available to review employee background checks. Severity: 2 Scope: 3 Complaint #NV00074346			
0920 SS= F	Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 1. Medication, including, without limitation, any over-the-counter medication, stored at a residential facility must be stored in a locked area that is cool and dry. The caregivers employed by the facility shall ensure that any medication or medical or diagnostic equipment that may be misused or appropriated by a resident or any other unauthorized person is protected. Medications for external use only must be kept in a locked area separate from other medications. A resident who is capable of administering medication to himself or herself without supervision may keep the resident ' s medication in his or her room if the medication is kept in a locked container	0920	Administrator has been assigned as the Administrator and has assumed responsibility for ensuring proper storage and security of all medications within the facility. All medications, including over-the-counter medications, are now stored in locked areas that are cool and dry. Medications for external use only are stored in a locked area separate from other medications. Medications requiring refrigeration are stored in a locked refrigerator, locked room, or locked container within the refrigerator to prevent unauthorized access. Measures to Prevent Recurrence • The Administrator has reviewed and reinforced medication storage policies	01/20/2026

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	for which the facility has been provided a key. 2. Medication stored in a refrigerator, including, without limitation, any over-the-counter medication, must be kept in a locked box unless the refrigerator is locked or is located in a locked room. Inspector Comments: Based on observation and interview, the facility failed to ensure medications were secure. Findings include: On 08/07/25 at 9:35 AM, upon entry into the facility, observed a bottle of eye drops on a tray table in the Living Room. There was no name on the bottle. The eye drops were not being administered to any resident at the time. On 08/07/25 at 10:35 AM, the Caregiver confirmed the eye drops belonged to R5. On 08/07/25 at 9:45 AM, observed two jars of A&D +E skin protectant and a bottle of shampoo and body wash on R6's bedside table. The Caregiver confirmed the observation and reported the shampoo was not supposed to be on the resident table. This was a repeat deficiency from the 01/21/25 annual State Licensure survey and complaint investigation. Severity: 2 Scope: 3		with all caregivers. • Caregivers are instructed to ensure that all medications and any medical or diagnostic equipment that could be misused are secured at all times. • Residents who are capable of self-administering medications may keep medications in their rooms only if stored in a locked container, with the facility maintaining access to a key. • External-use medications are clearly labeled and stored separately from internal medications. • Medication storage areas are monitored daily to ensure continued compliance. Monitoring System • The Administrator or designee will conduct routine inspections of all medication storage areas, including refrigerators. • Any deficiencies identified will be corrected immediately and addressed through staff re-education or corrective action as necessary. • Compliance will be monitored on an ongoing basis to ensure adherence to NAC 449.2748 requirements. Responsible Party Administrator Date of Compliance January 19, 2026	
0923 SS= F	Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 3. Medication, including, without limitation, any over-the-counter medication or dietary supplement, must be: (a) Plainly labeled as to its contents, the name of the	0923	Corrective Action Taken Administrator has been assigned and has assumed responsibility for ensuring that all medications, including over-the-counter medications and dietary supplements, are	01/20/2026

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	resident for whom it is prescribed and the name of the prescribing physician; and (b) Kept in its original container until it is administered. Inspector Comments: Based on observation and interview, the facility failed to ensure medications were in their original containers for storage. Findings include: On 08/07/25 at 9:59 AM, observed pre-poured medications in a medication cart in the kitchen. There were eight dose cups with pills in them. There were initials on the cups, but no resident name and no names of what was in the cups. On 08/07/25 at 10:00 AM, a Caregiver confirmed the medication was pre-poured into dose cups. The Caregiver reported they were helping the night shift Caregiver out with the medication administration. The Caregiver reported the medication in cups for future administration happened regularly. Severity: 2 Scope: 3		properly labeled and stored in their original containers. A review of all medications currently stored in the facility has been completed to verify that each medication is plainly labeled with: • The contents of the medication • The name of the resident for whom it is prescribed • The name of the prescribing physician Any improperly labeled medication or medication not in its original container was immediately corrected or removed from use until compliant. • **As part of the corrective action plan, caregivers were issued a memo reinforcing proper medication administration and prohibiting pre-pouring, in compliance with NRS 449 and NAC 449 requirements for group homes (see attached copy)** Measures to Prevent Recurrence • The Administrator has reviewed medication storage and labeling policies with all caregivers. • Caregivers have been re-educated that all medications, including over-the-counter medications and dietary supplements, must remain in their original containers until administered. • Staff are instructed to verify labeling upon receipt of medications and before administration. • Medications without proper labeling or original containers will not be administered and will be reported to the Administrator immediately. Monitoring System • The Administrator or designee will conduct routine audits of all medication storage areas to ensure compliance with	

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			labeling and container requirements. • Any deficiencies identified will be corrected immediately and addressed through staff re-training or corrective action as needed. • Ongoing compliance will be monitored to ensure adherence to NAC 449.2748(3). Responsible Party Administrator Date of Compliance January 19, 2026	
0991 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 and R043-22 Residential facility which provides care to persons with Alzheimer ' s disease: Standards for safety; personnel required; training for employees. (NRS 449.0302) 1. The administrator of a residential facility which provides care to persons with Alzheimer ' s disease or other forms of dementia who meet the criteria prescribed in paragraph (a) of subsection 2 of NRS 449.1845 shall ensure that: (b) Operational alarms, buzzers, horns or other technology for notifying staff when a door is opened are installed on all doors that may be used to exit the facility. Inspector Comments: Based on observation, document review and interview, the facility failed to ensure doors with alarms leading to the outside were activated. Findings include: On 08/07/25 at 9:35 AM, upon entry into the facility, there was no alarm activated on the front door.	0991	Corrective Action Taken As of January 19, 2026, the appointed as the Administrator and has assumed responsibility for ensuring compliance with Alzheimer’s care safety standards. The Administrator has conducted an assessment of all facility exit doors to determine the need for operational alarms, buzzers, horns, or other notification technology. All doors that may be used to exit the facility are being equipped with operational alarm systems to notify staff when a door is opened. Any door identified as lacking an alarm has been addressed and corrective action initiated to bring the facility into compliance. Please see attached copy of alarm notice in every exit. Measures to Prevent Recurrence	01/20/2026

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	The back door was also ajar. On 08/07/25 at 9:41 AM, observed a posted sign that read, ..."NOTICE PLEASE DON'T TURN OFF THE ALARM!!!" On 08/07/25 at 9:45 AM, the Caregiver acknowledged the front door alarm was not on. On 08/07/25 at 11:00 AM and at 11:55 AM, the back door alarm to the patio was not activated. A Caregiver was observed going in and out of the patio door. Severity: 2 Scope: 3		• The Administrator will ensure that all exit doors accessible to residents with Alzheimer's disease or other forms of dementia are equipped with functioning alarm systems. • Policies and procedures related to resident safety and elopement prevention have been reviewed and reinforced with staff. • Staff are trained to respond immediately to door alarms and to follow elopement prevention protocols. • Door alarms will be tested regularly to ensure proper operation. Monitoring System • The Administrator or designee will perform routine checks of all door alarms to verify they are operational. • Alarm functionality checks will be documented. • Any malfunction or deficiency will be corrected immediately and reported to the Administrator. • Ongoing compliance will be monitored to ensure continued adherence to NAC 449.2756 requirements. Responsible Party Administrator: Date of Compliance January 19, 2026	
1010 SS= D	Care for Persons with Mental Illnesses - NAC 449.2764 Residential facility which offers or provides care for persons with mental illnesses: Application for endorsement; training for employees. (NRS 449.0302) 1. A residential facility which offers or provides care and protective supervision for a resident with mental illness	1010	Plan of Correction Care for Persons with Mental Illnesses –Licensed for mental illness was aapplied as of 1/29/2026 Regulation: NAC 449.2764; NRS 449.0302	01/20/2026

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	must obtain an endorsement on its license authorizing it to operate as a residential facility for persons with mental illnesses. The Division may deny an application for an endorsement or suspend or revoke an existing endorsement based upon the grounds set forth in NAC 449.191 or 449.1915. Inspector Comments: Based on document review, record review and interview, the facility failed to ensure it had acquired a Mental Illness endorsement, to provide care and services for a resident admitted to the facility with a mental illness diagnosis. (Resident #4) Findings include: Resident #4 (R4) R4 had an unknown admit date. R4's record documented diagnoses including schizophrenia, bipolar disorder and dementia. On 08/07/25 in the afternoon, the Caregiver was unaware if the facility had a mental illness endorsement. On 08/07/25 in the afternoon, the State Aithent Licensing System (ALiS) confirmed the facility had no endorsement for mental illness. Severity: 2 Scope: 1 Complaint #NV00074346		Corrective Action Taken As of January 19, 2026, New Administrator has assumed responsibility for ensuring regulatory compliance related to services provided to residents with mental illnesses. The Administrator has reviewed the facility's current license status and resident population to verify whether an endorsement to operate as a residential facility for persons with mental illnesses is required. If the facility offers or provides care and protective supervision to residents with mental illness, the Administrator has initiated the process to apply for the required endorsement with the Division in accordance with NAC 449.2764. Any services provided will align strictly with the scope of licensure and endorsement. Measures to Prevent Recurrence • The Administrator will ensure the facility maintains the appropriate license endorsement prior to admitting or providing care to residents with mental illness. • Admission policies and procedures have been reviewed to verify resident eligibility based on the facility's licensure and endorsements. • Staff will be educated on the scope of services the facility is authorized to provide. • The Administrator will monitor regulatory requirements to ensure continued compliance with NAC 449.2764, NAC 449.191, and NAC 449.1915. Monitoring System • The Administrator will maintain documentation of licensure and endorsements on file and available for review. • Resident admission records will be	

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			reviewed to ensure alignment with licensing and endorsement requirements. • Ongoing compliance will be monitored through periodic administrative review and regulatory updates. Responsible Party Administrator Date of Compliance January 19, 2026 (mental Illness endorsement will be applied)	