Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	3671	A. BUILDING _____ B. WING _____	02/19/2026

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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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 a mandatory regrading State Licensure survey conducted at your facility on 02/19/26, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 10 Residential Facility for Group beds for elderly and disabled persons and/or Alzheimer's disease, Category II residents. The census at the time of the survey was six. Six resident files and four employee files were reviewed. The facility received a grade of A. 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 investigation, actions or other claims for relief that may be available to any party under applicable federal,			

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	state, or local laws. The following regulatory deficiencies were identified.			
Y 0883 SS= D	NAC 449.2742 7. If a resident refuses, or otherwise misses, an administration of medication, a physician, physician assistant or advanced practice registered nurse must be notified within 12 hours after the dose is refused or missed. Inspector Comments: Based on observation, document review, record review and interview, the Administrator failed to ensure the facility followed their medication policies and failed to ensure a physician was notified for 1 of 6 residents who refused medications. (Resident #3) Findings include: On 02/19/26 at 11:15 AM, observed three unidentified salmon-colored pills in a cup, located in the top drawer of a medication cart. The Caregiver identified the pills as Mirtazapine for Resident #3. A 09/06/26 physician order for Resident #3 documented Mirtazapine 30 milligrams (mg) 1 capsule at bedtime.	Y 0883	The doctor was notified of the refused medicatino, and the notification was documented in the resident's record. The resident was assessed, new instructions were followed. A review of all MARs was completed to ensure refused doses were not left unreported. The medication policy was reinforced to require reporting. notification within 12 hours of any refused dose. All staff were re-educated on proper medication documentation and timely reporting requirements. The Administrator will monitor MARs weekly to ensure continued compliance. Please see attached copy of DC order.	02/20/2026

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	On 02/19/26 at 11:30 AM, the Caregiver explained Resident #3 refused the Mirtazapine on 02/16/26, 02/17/26 and 02/18/26. The Caregiver reported telling Resident #3's Home Health nurse on the morning of 02/17/26 and 02/18/26 of the refusals, but had not contacted the nurse on 02/19/26 for the refused 02/18/26 dose of Mirtazapine. The Caregiver confirmed there was no documentation the refusals were reported to the Home Health nurse. The Medication Administration Record (MAR) documented the Mirtazapine as given on 02/16/26, 02/17/26 and 02/18/26, with Caregiver initials. The Caregiver whose initials were on the MAR, confirmed the Mirtazapine was refused by R3 and not administered on the three dates and explained the MAR should have been marked as refused. The facility's Medication Administration policy (undated), documented medication administration was documented on the resident's MAR at the time the medication was given by the person administering the dose, including an explanation if the medication was not taken.			

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	If the dose was omitted because of refusal, indicate the exact reason the resident gave for a refusal in the resident's words. Contact the resident's physician if a dose of a medication was not taken. The policy documented if a dose of a regularly scheduled medication was refused by the resident, it was to be reported to the Owner and/or Administrator for follow-up with the physician/prescriber. Make an Incident Report and call the physician. On 02/19/26 in the morning, there was no documentation the Mirtazapine refusals were reported to the Owner and/or the Administrator. There was no evidence Incident Reports were completed or that the physician was notified. On 02/19/26 at 11:25 AM, the Manager confirmed the MAR had Caregiver initials indicating the Mirtazapine was administered on 02/16/26, 02/17/26 and 02/18/26 to Resident #3 and the MAR should have been documented as refused. The Manager reported that normally an Incident Report was completed for a medication refusal and the physician was			

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	notified. The Manager confirmed there were no Incident Reports or physician notifications for Resident #3's three refused doses of Mirtazapine and there should have been. Severity: 2 Scope: 1			