STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	6324	A. BUILDING _____ B. WING _____	08/18/2025

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NEVADA MEMORY CARE	2299 MONTESSOURI ST, LAS VEGAS, NEVADA ,89117

(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 completed in your facility on 08/18/2025. The facility is licensed for 10 Residential Facility for Group beds for Category II residents with Alzheimer's disease. The census at the time of the survey was nine. Nine resident files and five employee files were reviewed. The facility received a grade of B.			
Y 0515 SS= F	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, social and recreational needs and involvement of ancillary services; (b) Protective supervision as necessary for	Y 0515	This plan of correctionis not to be construed as anadmission of or agreement with thefindings and conclusions in theStatement of Deficiencies, or theproposed administrative penalty(with right to correct) on thecommunity. Rather, it is submitted asconfirmation of our ongoing efforts tocomply with all statutory and regulatoryrequirements. Inthis document, we have outlined specific actions in response to each allegationor finding. We have not presented allcontrary factual or legal arguments, nor have we identified all mitigatingfactors.	10/04/2025

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	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 record review and interview, the facility failed to ensure a person-centered service plan was developed including the required components of Nevada Administrative Code 449.2754 for 9 of 9 residents (Residents #1, #2, #3, #4, #5, #6, #7, #8 and #9). Findings include: Resident #1 (R1) R1 was admitted to the facility on 09/01/24,		The facilitydesires that this plan of correction be considered the facility's allegation ofcompliance. **Y0515 Person Centered Service Plan NAC449.259** **I. HOW TO IDENTIFYOTHER RESIDENTS** A100% audit has been conducted to ensure that each resident's record include aperson centered service plan that includes all required elements. A completeperson centered service plan has been completed for any resident who wasidentified during the 100% audit as missing a required element. **II. SYSTEMIC CHANGES** Aspart of the admission process, a complete person centered service plan will becompleted for all residents. Additionally, at any resident's change ofcondition, or at least annually, a person centered service plan will becompleted and updated. **III. MONITORING PROCESS** Thisprocess will be monitored by the Administrator by conducting on-going monthlyaudits. **IV. DATE COMPLETION** Thisplan of correction has been completed by 10/4/2025.	

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	with diagnoses including dementia and hypertension. R1's file lacked documented evidence of a person-centered service plan to include the required components that describe the manner in which the facility would provide for the needs of R1, of how R1 would attend religious services of their choice, how to provide laundry services for R1 and how caregivers would be informed of the required supervision for R1. Resident #2 (R2) R2 was admitted to the facility on 05/30/25 with diagnoses including hypertension and heart disease. R2's file lacked documented evidence of a person-centered service plan to include the required components that describe the manner in which the facility would provide for the needs of R2, of how R2 would attend religious services of their choice, how to provide laundry services for R2 and how caregivers would be informed of the required supervision for R2. Resident #3 (R3) R3 was admitted to the facility on 12/28/24, with diagnoses including dyslipidemia and intestinal disease. R3's file lacked documented evidence of a person-centered service plan to include the required components that describe the manner in which the facility would provide for the needs of R3, of how R3 would attend religious services of their choice, how to provide laundry services for R3 and how caregivers would be informed of the required supervision for R3. Resident #4 (R4) R4 was admitted to the facility on 03/01/25, with diagnoses including dementia and hypertension. R4's file lacked documented evidence of a			

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	person-centered service plan to include the required components that describe the manner in which the facility would provide for the needs of R4, of how R4 would attend religious services of their choice, how to provide laundry services for R4 and how caregivers would be informed of the required supervision for R4. Resident #5 (R5) R5 was admitted to the facility on 12/23/24, with diagnoses including pre-diabetes and hypertension. R5's file lacked documented evidence of a person-centered service plan to include the required components that describe the manner in which the facility would provide for the needs of R5, of how R5 would attend religious services of their choice, how to provide laundry services for R5 and how caregivers would be informed of the required supervision for R5. Resident #6 (R6) R6 was admitted to the facility on 07/01/24, with diagnoses including Alzheimer's and hypertension. R6's file lacked documented evidence of a person-centered service plan to include the required components that describe the manner in which the facility would provide for the needs of R6, of how R6 would attend religious services of their choice, how to provide laundry services for R6 and how caregivers would be informed of the required supervision for R6. Resident #7 (R7) R7 was admitted to the facility on 03/01/25, with diagnoses including dementia and benign prostatic hyperplasia. R7's file lacked documented evidence of a person-centered service plan to include the required components that describe the manner in which the facility would provide for the needs of R7, of how R7 would attend			

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	religious services of their choice, how to provide laundry services for R7 and how caregivers would be informed of the required supervision for R7. Resident #8 (R8) R8 was admitted to the facility on 10/28/24, with diagnoses including Alzheimer's and chronic obstructive pulmonary disease. R8's file lacked documented evidence of a person-centered service plan to include the required components that describe the manner in which the facility would provide for the needs of R8, of how R8 would attend religious services of their choice, how to provide laundry services for R8 and how caregivers would be informed of the required supervision for R8. Resident #9 (R9) R9 was admitted to the facility on 03/01/25, with diagnoses including dementia. R9's file lacked documented evidence of a person-centered service plan to include the required components that describe the manner in which the facility would provide for the needs of R9, of how R9 would attend religious services of their choice, how to provide laundry services for R9 and how caregivers would be informed of the required supervision for R9. On 08/18/25 in the afternoon, the Administrator acknowledged a person-centered service plan was not developed for the nine residents which included the required components. Severity: 2 Scope: 3			

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Y 0991 SS= F	**NAC 449.2756 and R043-22** **Residential facility which provides care to persons with Alzheimer's disease: Standards for safety; personal required; training for employees.** (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 and interview, the facility failed to ensure all doors, which exited the facility, had an audible alarm. Findings include: On 08/18/25 in the morning, an exit door located next to bedroom #10 had an illuminated exit sign above the door and opened out to the side of the house leading down to the driveway with access to the street. The exit door did not have a functional audible alarm when the door was opened. On 08/18/25 in the morning, a Caregiver confirmed the exit door located next to bedroom #10 did not have a functional audible alarm when the door was opened and had been placed in the off position. The Caregiver did not know how long the alarm was in the off position. Severity: 2 Scope: 3	Y 0991	Y0991 Door Alarms NAC 449.2756 andR043-22 **I. HOW TO IDENTIFYOTHER SAFETY ISSUES** Alldoor alarms have been tested to ensure they are audible and functional. **II. SYSTEMIC CHANGES** Facilitystaff, Administrator and Owner will work to ensure that no door alarm isdeactivated or turned off and that they are functional and audible at alltimes. A check will be conducted at the beginning of each shift for all dooralarms. **III. MONITORING PROCESS** Thisprocess will be monitored by the Facility staff, Administrator and Owner byconducting on-going random walkthrough of the facility. IV. DATE COMPLETION Thisplan of correction has been completed by 10/4/2025.	10/04/2025
Y 0890 SS= E	NAC 449.2744 **Administration of medication: Maintenance of logs and records; contents.** 1. The administration of a residential facility	Y 0890	Y0890 Medication Administration andMaintenance of logs and records NAC 449.2744 **I. HOW TO IDENTIFYOTHER ISSUES**	10/04/2025

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	that provides assistance to residents in the administration of medications shall maintain: (a) A log for each medication received by the facility for use by a resident of the facility. The log must include: (1) The type and quantity of medication received by the facility; (2) The date of its delivery; (3) The name of the person who accepted the delivery; (4) The name of the resident for whom the medication is prescribed; and (5) The date on which any unused medication is removed from the facility or destroyed. (b) A record of the medication administered to each resident. The record must include: (1) The type of medication administered; (2) The date and time that the medication was administered; (3) The date and time that a resident refuses, or otherwise misses, an administration of medication; and (4) Instructions for administering the medication to the resident that reflect each current order or prescription of the resident's physician, physician assistant or advanced practice registered nurse, including, without limitation, whether the medication is to be administered according to a routine schedule or as needed; (5) Any change in an order or prescription of a resident's physician, physician assistant or advanced practice registered nurse, including, without limitation, the discontinuation of the medication; (6) Any time when the resident is out of the facility; and (7) Any mistakes made in the administration of medication. (Cross-reference to NAC 449.2742(5)) 2. The administrator of the facility shall keep a log of caregivers assigned to administer medications that indicates the shifts during which each caregiver was responsible for assisting in the administration of medication to a resident. This requirement may be met by including on a resident's medication sheet an indication of who assisted the resident in the administration of the medication, if the caregiver can be identified from this indication.		A100% audit of all medications ordered and in house has been performed to ensurethat they are all listed on the MAR. **II. SYSTEMIC CHANGES** Uponreceipt/delivery of any medication, staff will enter the medication in themedication log. The Med Tech on duty will then add the medication to the MARand store the medication in the resident's medication bin. An audit of thisprocess will be performed weekly by the Administrator. Staff has been trainedon this process. **III. MONITORING PROCESS** Thisprocess will be monitored by the Administrator weekly, until 100% compliancehas been achieved for a period of several consecutive months. After that, theAdministrator will perform monthly audits. **IV. DATE COMPLETION** Thisplan of correction has been completed by 10/4/2025.	

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	Inspector Comments: Based on record review and interview, the facility failed to ensure a medication was listed on the Medication Administration Record (MAR) for 2 of 9 residents. (Resident #4 and Resident #6). Findings include: Resident #4 (R4) R4 was admitted to the facility on 03/01/25 with diagnoses of dementia and hypertension. On 08/18/25 in the morning, Mirtazapine 30mg, take one per day for depression, was located in R4's medication bin with R4's name and room number labeled on the exterior. The delivery log documented the medication was delivered to the facility on 08/13/25. Mirtazapine 30mg was not listed on R4's Medication Administration Record (MAR) for August 2025. Resident #6 (R6) R6 was admitted to the facility on 07/01/24 with diagnoses of Alzheimer's and hypertension. Acetaminophen 650mg, take one tablet three times every day as needed, was located in R6's medication bin with R6's name and room number labeled on the exterior. The medication was not listed on the Medication Administration Record (MAR) for August 2025. On 08/18/25 in the morning, the Administrator was not able to explain why the medications were not listed on the MAR and why the as needed use was not listed			

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	on the MAR as well. Severity: 2 Scope:2			
Y 0876 SS= D	**NAC 449.2742** **Administration of medication: Responsibilities of administrator, caregiver and employees of facility.** 4. Except as otherwise provided in this subsection, a caregiver shall assist in the administration of medication to a resident if the resident needs the caregiver's assistance. A caregiver may assist the ultimate user of: (a) Controlled substances or dangerous drugs only if the conditions prescribed in subsection 6 of NRS 449.0302 are met. (b) Insulin using an auto-injection device only if the conditions prescribed in NRS 449.0304 and section 13 of this regulation are met. Inspector Comments: Based on interview and record review, the facility failed to ensure an ultimate user agreement was completed for 1 of 9 residents (Resident #2). Findings include: Resident #2 (R2) R2 was admitted on 05/30/25, with	Y 0876	**Y0876 Ultimate User Agreement NAC 449.2742** **I. HOW TO IDENTIFYOTHER ISSUES** A100% audit of all resident charts has been performed to ensure that allresidents have a signed Ultimate User Agreement on file. **II. SYSTEMIC CHANGES** Aspart of the admission process, an Ultimate User Agreement will be completed andfiled in each resident's file. **III. MONITORING PROCESS** Thisprocess will be monitored by the Administrator and Owner by monthly audits. **IV. DATE COMPLETION** Thisplan of correction has been completed by 10/4/2025.	10/04/2025

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	diagnoses including hypertension and heart disease. R2's file lacked documented evidence of a signed ultimate user agreement. On 08/18/25 in the morning, the Administrator acknowledged R2's file lacked documented evidence of a signed ultimate user agreement. Severity: 2 Scope: 1			
Y 1600 SS= C	**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 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	Y 1600	**Y1600 Gender Identity or Expressionand Preferred Name NAC 449.011943 and R004-24** **I. HOW TO IDENTIFYOTHER ISSUES** A100% audit of all resident charts has been performed to ensure that allresidents have a record of their Gender Identity or Expression and PreferredName. **II. SYSTEMIC CHANGES** Aspart of the admission process, an Admission Record will be completed that willinclude a space for the resident's Gender Identity or Expression and PreferredName. **III. MONITORING PROCESS** Thisprocess will be monitored by the Administrator and Owner by monthly audits. **IV. DATE COMPLETION** This plan ofcorrection has been completed	10/04/2025

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	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 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		by 10/4/2025	

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	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 ensure that 7 of 9 resident files included documentation of preferred pronoun, gender expression and sexual orientation (Resident #2, #3, #4, #5, #7, #8, and #9). Findings include: Resident #2 (R2) R2 was admitted to the facility on 05/30/25 with diagnoses including hypertension and heart disease. R2's file lacked documented evidence of gender identity or expression and preferred name. Resident #3 (R3) R3 was admitted to the facility on 12/28/24,			

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	with diagnoses including dyslipidemia and intestinal disease. R3's file lacked documented evidence of gender identity or expression and preferred name. Resident #4 (R4) R4 was admitted to the facility on 03/01/25, with diagnoses including dementia and hypertension. R4's file lacked documented evidence of gender identity or expression and preferred name. Resident #5 (R5) R5 was admitted to the facility on 12/23/24, with diagnoses including pre-diabetes and hypertension. R5's file lacked documented evidence of gender identity or expression and preferred name. Resident #7 (R7) R7 was admitted to the facility on 03/01/25, with diagnoses including dementia and benign prostatic hyperplasia. R7's file lacked documented evidence of gender identity or expression and preferred name. Resident #8 (R8) R8 was admitted to the facility on 10/28/24, with diagnoses including Alzheimer's and chronic obstructive pulmonary disease. R8's file lacked documented evidence of gender identity or expression and preferred name. Resident #9 (R9) R9 was admitted to the facility on 03/01/25, with diagnoses including dementia. R9's file lacked documented evidence of gender identity or expression and preferred name. On 08/18/25 in the morning, the Administrator acknowledged Resident #2, #3, #4, #5, #7, #8, and #9's file lacked documentation of gender identity or expression and preferred name. Severity: 1 Scope: 3			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	6324	A. BUILDING _____ B. WING _____	08/18/2025

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Y 1700 SS= D	**NRS 449.1845** **Administrator of residential facility for groups to conduct annual assessment of history of each resident and cause provider of health care to conduct certain examinations and assessments; placement based on assessment.** 1. The administrator of a residential facility for groups shall: (a) Annually cause a qualified provider of health care to conduct a physical examination of each resident of the facility; (b) Annually conduct an assessment of the history of each resident of the facility, which must include, without limitation, an assessment of the condition and daily activities of the resident during the immediately preceding year; and (c) Cause a qualified provider of health care to conduct an assessment of the condition and needs of a resident of the facility to determine whether the resident meets the criteria prescribed in paragraph (a) of subsection 2: (1) Upon admission of the resident to the facility; and (2) If a physical	Y 1700	**Y1700 Physician PlacementDetermination NAC 449.1845** **I. HOW TO IDENTIFYOTHER ISSUES** A100% audit of all resident charts has been performed to ensure that allresidents have a signed Physician Placement Determination in their file. **II. SYSTEMIC CHANGES** Aspart of the admission process, a Physician Placement Determination form will becompleted and signed by a physician prior to that resident's admission to thefacility. **III. MONITORING PROCESS** Thisprocess will be monitored by the Administrator and Owner by monthly audits. **IV. DATE COMPLETION** Thisplan of correction has been completed by 10/4/2025.	10/04/2025

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	examination, assessment of the history of the resident or the observations of the administrator or staff of the facility, the family of the resident or another person who has a relationship with the resident indicate that: (I) The resident may meet those criteria; or (II) The condition of the resident has significantly changed. 2. If, as a result of an assessment conducted pursuant to paragraph (c) of subsection 1, the provider of health care determines that the resident: (a) Suffers from dementia to an extent that the resident may be a danger to himself or herself or others if the resident is not placed in a secure unit or a facility that assigns not less than one staff member for every six residents, any residential facility for groups in which the resident is placed must meet the requirements prescribed by the Board pursuant to subsection 2 of NRS 449.0302 for the licensing and operation of residential facilities for groups which provide care to persons with Alzheimer's disease or other severe dementia. (b) Does not suffer from dementia as described in paragraph (a), the resident may be placed in any residential			

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	facility for groups. 3. As used in this section, “provider of health care” has the meaning ascribed to it in NRS 629.031. (Added to NRS by 2019, 2594) Inspector Comments: Based on record review and interview, the facility failed to ensure an initial placement assessment was obtained for 3 of 9 residents (Resident #2, Resident #3, and Resident #9). Findings include: Resident #2 (R2) R2 was admitted on 05/30/25 with a diagnosis of hypertension and heart disease. R2's resident file lacked documented evidence of an initial physician placement assessment. Resident #3 (R3) R3 was admitted on 12/28/24 with a diagnosis of dyslipidemia and intestinal disease. R3's resident file lacked documented evidence of an initial physician placement assessment. Resident #9 (R9) R9 was admitted on 02/28/25 with a diagnosis of dementia. R9's resident file lacked documented evidence of an initial physician placement assessment.			

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	On 08/18/25 in the morning, the Administrator acknowledged R2's, R3's and R9's resident files lacked documented evidence of an initial physician placement assessment. Severity: 2 Scope:1			