

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 8700	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/23/2024
NAME OF PROVIDER OR SUPPLIER ELKHORN JONES MEMORY CARE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 6017 ELKHORN ROAD, LAS VEGAS, NEVADA ,89131		
(X4) ID PREFIX TAG 0000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG 0000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a State licensure survey completed in your facility on 07/23/24, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facilities for Groups. The facility is licensed for 28 Residential Facility for Group beds for elderly and disabled persons, and/or persons with Alzheimer's disease, Category II residents. The facility has applied for an eight-bed increase and was approved to add eight group beds which provide services for 36 group beds for elderly and disabled persons, and/or persons with Alzheimer's disease, Category II residents. The findings and conclusions of any investigation by the Division of Public and Behavioral Health 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, state, or local laws. There were no regulatory deficiencies identified. Maintain a copy for your records.			

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 Name: _____ Title: _____ Date: _____
REPRESENTATIVE'S SIGNATURE