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 _____	**01/14/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAS VEGAS ALZHEIMER AND MEMORY CARE 1	**3224 BRAZOS STREET, LAS VEGAS, NEVADA ,89169**

(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
0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation conducted at your facility on 01/14/25, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facilities for Groups. The census at the time of survey was seven. The sample size was two. The facility received a grade of A. One complaint was investigated. Substantiated Without Deficient Practice: 1. Complaint #NV00072919 was substantiated without deficient practice. The investigation into the complaint included: Observations of residents without wounds and staff caring for residents. Interviews with a Caregiver and Administrator. Clinical record review of residents, including the resident of concern. Document review of Resident Agreement, Resident Rights and Staff phone/text communications. 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. The following regulatory deficiencies were identified.	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: TOLENTINO TAN Title: ADMINISTRATOR Date: 02/24/2025

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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0826 SS= D	Tracheostomy or Open Wound - NAC 449.2734 Residents having tracheostomy or open wound requiring treatment by medical professional; residents having pressure or stasis ulcers. (NRS 449.0302) 3. The administrator of the facility shall ensure that records of the care provided to a person who has a pressure or stasis ulcer pursuant to subsection 2 are maintained at the facility. The records must include an explanation of the cause of the pressure or stasis ulcer. Inspector Comments: Based on record review and interview, the facility failed to maintain documentation of the care for pressure ulcers for 1 of 2 residents. (Resident #1) Findings include: Resident #1 (R1) R1 was admitted on 08/22/24 with diagnoses including severe dementia and hypokalemia. R1's records documented R1 was admitted to the hospital on 11/12/24 with a Stage IV sacral ulcer and a Stage III pressure ulcer on the right foot which needed wound care. On 01/14/25 in the morning, R1's Activities of Daily Living (ADL) Record lacked documented evidence of pressure ulcers and the care for them. On 01/14/25 at 9:35 AM, a Caregiver reported R1 started not getting up from bed, was not eating and was developing a pressure ulcer. The Caregiver reported the facility did not have progress notes or documentation for R1's pressure ulcers and did not communicate on when R1 had obtained the pressure ulcers. On 01/14/25 in the afternoon, the Administrator confirmed R1 had pressure ulcers and had not been successful in getting wound care for them. R1 was sent to the hospital on 11/12/24 and the Administrator confirmed there was no documentation of any pressure ulcers or wounds in R1's record. On 01/14/25 in the morning, the facility could not communicate as to when the resident obtained the pressure ulcers. Severity: 2 Scope: 1	0826	1. All caregivers are reminded to make an incident report or document any changes in recipient's health condition, illness or injury including the date and time of the discovery and notify the administrator to ensure appropriate care/medical attention is provided accordingly. 2. Copies of incident report form and progress notes forms are provided in the resident's file to be completed by the caregiver upon discovery of changes in health condition, accidents, illness or injury. 3. Administrator will monitor the completion of the form and the appropriate actions taken. 4. Administrator. 5. 1/14/2025. 6. Incident Report Form and Progress Notes attached	01/14/2025

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0830 SS= D	Exemption Requests - NAC 449.2736 Procedure to exempt certain residents from restrictions. (NRS 449.0302) 1. The administrator of a residential facility may submit to the Division a written request for permission to admit or retain a resident who is prohibited from being admitted to a residential facility or remaining as a resident of the facility pursuant to NAC 449.271 to 449.2734, inclusive. Inspector Comments: Based on document review, record review and interview, the facility failed to ensure a medical exemption for pressure ulcers was submitted to the Bureau to retain 1 of 2 sampled residents. (Resident #1). Findings include: Resident #1 (R1) R1 was admitted on 08/22/24 with diagnoses including severe dementia and hypokalemia. R1's record lacked documented evidence R1 was admitted with wounds. On 01/14/25 at 9:35 AM, a Caregiver reported R1 started not getting up from bed, was not eating and was developing a pressure ulcer. The Caregiver explained if a resident developed a pressure ulcer, the facility would call someone to provide wound care, the Caregiver reported the facility was not allowed to treat wounds. The Caregiver reported around 11/07/24, staff called the public guardian to request an agency come and address R1's pressure ulcer. On 01/14/25 in the afternoon, the surveyor reviewed a log of phone calls on the Administrator's cell phone to and from R1's public guardian, between 11/07/24 and 11/12/24. The Administrator explained the calls to the guardian were an attempt to acquire wound care services for R1. R1's records documented R1 was admitted to the hospital on 11/12/24 with a Stage IV sacral ulcer and a Stage III pressure ulcer on the right foot. R1's file lacked documented evidence of an application submitted to the Bureau for a medical exemption for a Stage IV sacral ulcer wound and pressure ulcer. On 01/14/25 in	0830	1. The facility administrator has to submit to the bureau a written request for permission to admit or retain a resident who is developing a pressure sore. 2. The caregivers are reminded to notify the facility administrator of any skin redness/breakdown that may result to a pressure sore to ensure proper steps be taken as to the management of such, including submitting an application to HCQC permission to retain the resident. 3. The administrator will monitor and submit whenever necessary an application to retain a resident who is developing a pressure sore. 4. Administrator. 5. Resident was transferred/discharged to Sunrise Hospital 11/12/2024 for wound care/pressure sore treatment. 6. Resident Discharge/Transfer Form attached.	02/24/2025

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	the afternoon, the Administrator confirmed R1 had the pressure ulcers and had not been successful in getting services for R1's wounds. R1 was sent to the hospital on 11/12/24 and the Administrator confirmed there was no documentation of a medical exemption being submitted to the Bureau so the facility could retain R1 as a resident. On 01/14/25 in the morning, the facility could not communicate when the resident obtained the wounds. Severity: 2 Scope: 1			
0853 SS= D	Medical Care of Resident After Illness - NAC 449.274 Medical care of resident after illness, injury or accident; periodic physical examination of resident; rejection of medical care by resident; written records. (NRS 449.0302) 3. A written record of all accidents, injuries and illnesses of the resident which occur in the facility must be made by the caregiver who first discovers the accident, injury or illness. The record must include: (a) The date and time of the accident or injury or the date and time that the illness was discovered; (b) A description of the manner in which the accident or injury occurred or the manner in which the illness was discovered; and (c) A description of the manner in which the members of the staff of the facility responded to the accident, injury or illness and the care provided to the resident. This record must accompany the resident if he or she is transferred to another facility. Inspector Comments: Based on document review, record review and interview, the facility failed to ensure incident reports were completed for 1 of 2 residents who had a change of condition. (Resident #1) Findings include: Resident #1 (R1) R1 was admitted on 08/22/24 with diagnoses including severe dementia and hypokalemia. R1's records documented R1 was admitted to the hospital on 11/12/24 with a Stage IV sacral ulcer and a Stage III pressure ulcer on the right foot. On 01/14/25 at 9:35 AM, a Caregiver reported R1 started not getting up from bed, was not eating and was	0853	1. Caregivers are reminded to make an incident report or document any changes in recipient's health condition, illness, accident or injury at the time of discovery and notify the administrator to ensure appropriate care/medical attention is provided accordingly. 2. Caregivers are instructed to find copies of incident report form and progress notes form in the resident's file, and to fill out the form upon discovery of any changes in resident's health condition, accidents, illness or injury. 3. Administrator will monitor the completion of the form and the appropriate actions taken. 4. Administrator. 5. 1/14/2025. 6. Incident Report Form and Progress Notes attached.	01/14/2025

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	developing a bed sore. The Caregiver reported there were no progress notes or Incident Reports regarding R1's pressure ulcers. The facility's Serious Occurrence Report policy documented the provider must keep a daily record of services provided to a resident, and providers must report any recipient incident to a case manager within 24 hours of discovery. On 01/14/25 in the morning, the facility could not communicate when the resident obtained the wounds. On 01/14/25 at 11:00 AM, the Administrator confirmed R1 had developed pressure ulcers prior to going to the hospital on 11/12/24. On 01/14/25 in the morning, the Administrator reported any incidents or trips to the hospital should be documented on an Incident Report. The Administrator confirmed there were no Incident Reports completed for R1. Severity: 2 Scope: 1			