

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 A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/27/2025	
NAME OF PROVIDER OR SUPPLIER LAS VEGAS ALZHEIMER AND MEMORY CARE 2				STREET ADDRESS, CITY, STATE, ZIP CODE 3225 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 completed in your facility on 1/27/25, in accordance with Nevada Administrative Code (NAC), Chapter 449, Residential Facilities for Groups. The census at the time of the survey was ten. Five resident files were reviewed. The facility received a grade of A. There was one complaint investigated. Substantiated with out deficiencies: Complaint #NV00072920 was substantiated without deficiencies. The investigation of complaint included: Observation of grooming and physical appearance for residents, resident interactions with staff, and a tour of the facility. Interviews were conducted with Caregivers, Residents and the Administrator. Record Review of five records, which included the resident of concern. 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 Name: CHRIS C. TAN
REPRESENTATIVE'S SIGNATURE

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.

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 A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/27/2025
NAME OF PROVIDER OR SUPPLIER LAS VEGAS ALZHEIMER AND MEMORY CARE 2			STREET ADDRESS, CITY, STATE, ZIP CODE 3225 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
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 interview and record review, the facility failed to ensure an incident report was completed for a resident who had a change of condition for 1 of 5 residents (Resident #1). Findings include: Resident #1 (R1) R1 was admitted to the facility on 11/3/23 with a diagnosis of dementia, hypertension, history of breast cancer and depression. On 01/27/25 in the morning, the Administrator indicated R1's feet were swollen, and blue and medical staff were called to perform an X-ray and ultra sound on R1's foot. Subsequently, R1 was diagnosed with bilateral deep vein thrombosis (DVT) and was prescribed Eliquis 5 milligram (MG) two times a day (BID). R2's file lacked documented evidence of an incident report for the change of condition. On 01/27/2025 in the afternoon, the Administrator acknowledged an Incident Report had not been completed. The Administrator indicated an incident report should have been completed for the change of condition. Severity: 2 Scope: 1	0853	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. 1/27/2025. 6. Incident Report Form	01/27/2025

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

PRINTED: 6/15/2026
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/27/2025
NAME OF PROVIDER OR SUPPLIER LAS VEGAS ALZHEIMER AND MEMORY CARE 2			STREET ADDRESS, CITY, STATE, ZIP CODE 3225 BRAZOS STREET, LAS VEGAS, NEVADA ,89169	
(X4) ID PREFIX TAG 0930 SS= D	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG 0930	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE 01/27/2025
	Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he or she permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including, without limitation: (a) The full name, address, date of birth and social security number of the resident. (b) The address and telephone number of the resident ' s physician and the next of kin or guardian of the resident or any other person responsible for the resident. (c) A statement of the resident ' s allergies, if any, and any special diet or medication he or she requires. Inspector Comments: Based on observation, interview and document review, the facility failed to ensure resident records were retained for at least 5 years after a resident was discharged from the facility for 1 of 5 sampled residents. (Resident #1) Findings include: On 01/27/25 in the morning, the facility was unable to provide a representative from the Bureau of Health Care Quality and Compliance the records of Resident #1 (R1) who was a previous resident of the facility. On 01/27/25 in the morning, Employee #1 (E1) confirmed R1 was a resident of the facility and was admitted in the beginning of November 2023. E1 verbalized an employee mistakenly gave R1's file to R1's transport when R1 left the facility. On 01/27/25 in the morning, the Administrator acknowledged R1's complete file was not onsite and should have been. The Administrator verbalized all resident files should be retained by the facility for at least five years. On 01/27/25 in the morning, E1		1. Caregivers are reminded to keep a record of incident reports and/or progress notes in the resident's file and to keep that file for at least 5 years after the resident has permanently left the facility. 2. Caregivers were instructed to document incident reports/progress notes and to keep that documentation in the resident's file and to keep that file for at least five years in the facility for compliance. 3. Administrator has designated the main caregiver to store in a locked cabinet residents' files for at least 5 years after they have left the facility permanently. 4. Administrator/Main caregiver. 5. 1/27/2025 6. Old files stored in a locked cabinet.	

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

PRINTED: 6/15/2026
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/27/2025	
NAME OF PROVIDER OR SUPPLIER LAS VEGAS ALZHEIMER AND MEMORY CARE 2				STREET ADDRESS, CITY, STATE, ZIP CODE 3225 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	
	acknowledged resident records should be retained per policy with documented, all resident chart and resident medication records would be retained for 5 years following termination of service to the resident. Severity: 2 Scope: 1						