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 _____	**07/12/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AEGIS LIVING LAS VEGAS	**9100 WEST DESERT INN RD., 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
0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint survey conducted at your facility on 07/12/22, in accordance with Nevada Administrative Code Chapter 449, Residential Facilities for Groups. The facility is licensed for 72 Residential Facility for Group beds for elderly or disabled persons and/or persons with Alzheimer's disease and Assisted Living services, Category II residents. The census at the time of the survey was 40. The sample size was five. The facility received a grade of A. One complaint was investigated. Complaint #66464 with two allegations was substantiated without deficiencies. Allegation #1 A resident was found with a black eye and their pants down was substantiated without deficiencies based on review of an incident report which documented the resident was found with a swollen eye and pants were just below the waist. The Administrator and Care Manager indicated the resident wore leggings often and typically slid down the resident's bottom due to not fitting properly when wearing an incontinence brief. A documented statement from the night shift caregiver reported being unaware of how the resident obtained a swollen eye and had not witnessed the resident fall. The Care Manager reported the resident had a swollen left eye with some redness and was unaware of how the injury occurred. The Care Manager indicated the resident had a history of falling and hitting her face on a dresser on one occasion. When the care staff found the resident with eye redness and swelling on 04/02/22, the facility assessed the resident, called the physician and family, and was transported to the hospital. Residents resided in memory care and were not interviewable. Allegation #2 The facility failed to report sexual abuse allegations to the Bureau was substantiated without deficiencies based on interview with the	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: Title: Date:

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	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**07/12/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AEGIS LIVING LAS VEGAS	**9100 WEST DESERT INN RD., 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
	Administrator, Associate Care Director, Medication Technician, and Care Manager who reported they were present the morning the resident was found to have swelling and redness around the eye, and there was not a concern sexual abuse had occurred, and therefore did not report the incident. The facility conducted an internal investigation, which brought the facility to these findings. The Administrator and Care Manager indicated the resident had worn leggings the morning of the incident and when the resident wore leggings, they historically slid down below her waist due to the incontinence brief making them not fit properly. The investigation into the allegations included: Observations of resident appearances. Interviews with the Administrator, Associate Care Director, Medication Technician, and Care Manager. Record review of five resident files including the resident of concern. Document review of statements from staff and sensor report which indicated when staff entered a resident's room. No regulatory deficiencies were identified. No further action necessary. Please retain a copy for your records.			