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 _____	**08/10/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AEGIS LIVING LAS VEGAS	**9100 WEST DESERT INN RD., LAS VEGAS, NEVADA ,89117**

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a Facility Reported Incident investigation initiated at your facility on 07/14/23 and completed on 08/10/23, in accordance with Nevada Administrative Code (NAC) 449, Residential Facility for Groups. The census at the time of the survey was 51. The sample size was two. There were two Facility Reported Incidents (FRI's) investigated. Verified: 1. FRI #8597 was verified. (See Tag Y0515) 2. FRI #8636 was verified. (See Tag Y0515) The investigation of Facility Reported Incidents included: Observation of grooming and physical appearance for residents and a tour of the facility. Interviews were conducted with residents and the Administrator. Clinical Record Review of two records, which included the residents of concern. Document Review included facility policy and procedures, staff schedules, incident reports, and written statements by staff. 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 deficiency was identified:	0000		
0515 SS= H	Supervision and Treatment of Residents - NAC 449.259 Supervision and treatment of residents generally. (NRS 449.0302) 1. A residential facility shall: (a) Provide each resident with protective supervision as necessary; (b) Inform all caregivers of the required supervision; Inspector Comments: Based on observation, record review, and interview, the facility failed to provide protective supervision for 2 of 2 sampled residents with dementia diagnoses (Resident #1 and #2). Findings include: Resident #1 (R1) R1	0515	FRI# 8597 1) Routine checks and Courtyard Routine checks during excessive heat were implemented to ensure all residents are safe 2) Routine checks and Courtyard Routine checks during excessive heat, motion sensors with alarms next to the courtyard door 3) Resident Care director or designee to ensure the check forms are used during excessive heat and the Montion alarms are on 4) Resident Care director or designee	07/23/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: ALEX BETANCOURT Title: GM Date: 11/20/2023

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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	was admitted to the facility on 05/01/23, with diagnoses including unspecified dementia, severe, with agitation. The entire facility is a locked memory care unit with three hallways of apartments and a main lobby area connecting the three hallways. Each hallway has access to its own outdoor courtyard area for residents' use, with the center courtyard door located in the lobby area of the facility. Each door leading to the courtyards were properly alarmed. R1's Individualized Service Plan documented beginning on 05/25/23, R1 experienced anxiousness, mood changes, or restlessness, time/place disorientation, combative and/or destructive behaviors. An incident report dated 07/11/23 documented at 11:15 AM, R1's wife and son arrived at the facility to visit with R1. When R1's family arrived at the facility R1's whereabouts were unknown and R1 was last seen at 8:45 AM in the lobby area. A search for R1 was initiated and R1 was found in the center outdoor courtyard area at 11:30 AM. R1 was found sitting on a bench with R1's shirt unbuttoned/opened, hat set to the side, shoes slipped off, and unresponsive. Caregivers placed a cold damp cloth on R1's forehead and called Emergency Medical Services (EMS). At 11:45 AM, EMS arrived at the facility and, after an assessment of R1, R1 was transported to the hospital for further evaluation. The incident included three written statements from employees indicating R1 was outside for three hours. On 07/14/23 at 12:45 PM, the Administrator acknowledged R1 was outside in the center courtyard for about three hours. The door leading to the center courtyard is located in the lobby of the locked memory care facility. The Administrator revealed the lobby area has a staff member assigned to the area from 8:00 AM to 8:00 PM, but that staff member did not witness R1 going outside. In addition, caregivers are assigned to a specific hallway of apartments, referred to as neighborhoods. A review of the staff		5) 7/20/2023 FRI#8636 1) Staff retrain on Elopment Protocol and Intervention 2) The front door alarmed hours adjusted to reflect the receptionist business hours. Exit seeking residents are offered escorted walks to minimize the risk of elopement. 3) Maintenance Director, Resident Care director or designee will ensure implemented changes are in place 4) Maintenance Director, Resident Care director or designee 5) 7/23/2023	

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	schedule for the week of the incident shows adequate staff on duty at the time of the incident and a ratio of one staff member for every five residents. The Incident Report also documented it was R1's daily routine to go outside on the patio. There was no documented evidence R1 was provided a protective supervision plan for these behaviors from 05/25/23, the date R1's behaviors were documented on the service plan to the date of the incident on 07/11/23. Review of the weather report for 07/11/23 revealed Las Vegas temperatures were expected to be at 100 degrees Fahrenheit by 11:00 AM. The Las Vegas daytime temperature for 07/11/23 was recorded at 109 degrees Fahrenheit. A Hospital Discharge Summary dated 07/27/23, revealed R1 suffered from dehydration/heat exhaustion and blisters on the dorsum of right foot after being suspected of being outside for about three hours. In addition, the hospital records revealed R1 indicated going outside in the sun often to enjoy the heat and was not allowed to be outside alone. A review of the written statement by Employee #3 (E3) revealed E3 last saw R1 at about 8:30 AM, when R1 left the dining room. E3 remained in the dining room attending to resident needs, washing dishes, and cleaning up. After those tasks were completed, E3 began assisting residents with bathing and toileting duties until 10:00 AM, when E3's break began. A review of the written statement by Employee #4 (E4) revealed at 11:28 AM, E4 completed a break and was returning to the floor when E4 saw R1's family looking for R1. E4 began searching for R1 by going to the lobby and asking the receptionist if they had seen R1. The receptionist indicated not seeing R1. E4 then exited the lobby to search the outside patio area. E4 located R1 and attempted to talk with R1. When R1 was unresponsive to E4's questions, E4 notified the nurse, who went to check on R1. Upon seeing R1, the nurse sent E4 to notify administration and get a damp cloth			

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	for R1's forehead. A review of facility policy 'Managing Aggressive Behavior' revealed interventions and outcomes should be documented in the Progress Notes section of the resident's Individualized Service Plan, additional documentation may be required such as, unusual occurrence report and investigation, temporary service plans, or change of condition forms, and staff should always be familiar with resident service plans. A review of facility policy 'Heat-related Illness Prevention Guidelines' documented the following precautions should be followed during periods of warm weather: - Avoid outdoor activities during midday (approximately 11:00 AM to 3:00 PM) - Limit sun exposure anytime, provide plenty of shade when outdoors - Closely monitor for the signs/symptoms of heat-related illness, those residents at greatest risk. - Take extra precautions with residents who have dementia. On 09/07/23 at 2:30 PM, the Business Office Manager indicated caregivers should have implemented checks of all outdoor areas when temperatures reached 100*F. R1's file lacked documented evidence of an individualized plan of how R1 would be monitored, provided protective supervision, and protected from extreme weather conditions. In addition, there was no documented evidence the facility had performed periodic checks on R1 on 07/11/23. Resident #2 (R2) R2 was admitted to the facility on 07/03/23, with diagnoses including unspecified dementia. The facility is a locked memory care facility with three halls of apartments and three outdoor courtyard areas for residents to use. An individualized service assessment dated 07/05/23 noted R2 "seeks out, loiters near, or attempts to exit through doors and/or windows. An incident report dated 07/22/23, documented between 7:15 AM and 7:30 AM, R2 eloped from the facility via the main entrance. At 7:30 AM, when caregivers did not see R2 at breakfast a search of the facility was initiated. At 9:40			

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	AM, the Health Service Director was notified R2's whereabouts were unknown, and another search of the facility was conducted. At 10:30 AM, police were called after R2 could not be found. At 10:40 AM, police officers arrived at the facility and, after a brief description, notified the facility R2 was located at the hospital. R2 was examined at the hospital and discharged back to the facility after confirming R2 did not suffer any injuries. A review of R2's Individualized Service Plan dated 08/16/23 revealed the facility was aware of R2's exit seeking behaviors upon admission and were to be conducting hourly checks requiring caregivers to physically locate R2 on a 24-hour basis. On 08/10/23 at 10:50 AM, the Administrator indicated the main entrance was monitored by a staff member between 8:00 AM and 8:00 PM and there was no staff member at the main entrance providing supervision of the area when R2 eloped. On 07/22/23 at 7:30 AM, Caregivers noticed R2 was missing when R2 did not show up for breakfast. Caregivers began to search for R2 but were unsuccessful and failed to notify the Manager on Duty and/or contact police for two hours. On 08/10/23 at 11:30 AM, the Administrator acknowledged the facility failed to provide protective supervision for R1 and R2. Severity: 3 Scope: 2			