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 _____	**09/03/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HOUSE OF SOUTHERN HILLS	**9750 W. SUNSET ROAD, LAS VEGAS, NEVADA ,89148**

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a Complaint Investigation survey completed in your facility on 09/05/24, in accordance with Nevada Administrative Code, Chapter 449, Requirements for Residential Facilities for Groups. The census at the time of the survey was 140. The sample size was five. The facility received a grade of A. One complaint was investigated: Substantiated: 1. Complaint #NV00071699 was substantiated. (See TAG Y0556) The investigation into the complaint included: - Interviews conducted with the Owner/Director, the Administrator, Medication Technicians and Caregivers. - Record review of resident records, including the resident of concern. -Document review including facility policies and procedures and Incident Reports. 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 investigations, 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		
0556 SS= D	Provision of Dental, Optical and Hearing Care - NAC 449.262 Provision of dental, optical and hearing care and social services; report of suspected abuse, neglect, isolation or exploitation; restrictions on use of restraints, confinement or sedatives. (NRS 449.0302) 2. If an employee of the facility suspects that a resident is being abused, neglected, isolated or exploited, the employee shall report that fact in the manner prescribed in NRS 200.5093. Inspector Comments: Based on record review and interview, the facility failed to ensure an allegation of abuse was reported to Adult Protective Services (APS) as	0556	**Plan of Correction: Abuse Prevention (Tag 0556)** 1. **Corrective Action for Affected Residents:** Abuse prevention training will be provided by Resident Care Coordinators (RCCs) and monitored by the Wellness Director to all current staff by 11/22/2024. Any staff members who were not trained prior to this date will be required to complete training before returning to their regular duties. 2. **Identification of Other Potentially Affected Residents:** A review of all residents will be conducted to	10/22/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: MICHAEL MASICH Title: Executive Director Date: 10/22/2024

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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	described in Nevada Revised Statutes (NRS) 200.5093. Findings include: Resident #1 (R1) R1 was admitted on 05/31/24 with primary diagnoses including depression, dementia, vertigo, pruritis, senile degeneration of the brain, liver cancer, hypertension and muscle weakness. R1's medications were discontinued on 06/03/24 by a physician due to R1 refusing them and declining health per the Hospice agency. On 09/03/24 at 11:40 AM, the Resident Care Coordinator (RCC) explained R1 refused R1's medications saying R1's family was trying to kill R1. R1 had no trust of anyone for medications or food. A facility Charting Note dated 06/07/24 at 12:00 AM, documented the Memory Care Coordinator (MCC) was notified by Caregivers that R1 was telling the staff R1's family member was trying to kill R1. The staff was concerned about R1's well being. There was no documented evidence the facility notified APS regarding R1's allegation of abuse on 06/07/24. A facility Charting Note dated 06/09/24 at 5:00 PM, documented the MCC reported to the Executive Director and Wellness Director (WD) that the staff was concerned about R1's safety and well being. There was no documented evidence the facility notified APS regarding R1's allegation of abuse and staff's concerns on 06/09/24. A facility Charting Note dated 06/10/24 at 11:12 AM, documented a Medication Technician (Med Tech) observed R1's cup of apple juice was on the bathroom counter. Three staff members went in to check on R1 and noticed the cup with apple juice on the bathroom sink counter. A Caregiver opened the cup and smelled it, and reported the cup smelled like strong alcohol. The Caregiver asked R1 if their family gave R1 alcohol, R1 replied yes. A second Caregiver showed the cup to R1 and again asked R1 if the cup had alcohol in it and R1 replied yes. There was no documented evidence the facility notified APS regarding R1's comments and allegations of abuse on 06/10/24. A facility		ensure that no further instances of abuse or neglect have occurred. This will include resident interviews, staff assessments, and incident report reviews. Any resident identified as potentially affected will receive immediate intervention and support. 3. **Systemic Changes to Ensure Deficiency Will Not Recur:** ◦ Abuse prevention education will be provided in person during shift change to all current staff by 11/22/2024. Moving forward, all new hires will receive abuse prevention training as part of their orientation. ◦ Annual refresher training on abuse prevention will take place on the anniversary of the staff member's hire date, with documentation maintained in personnel files. ◦ Refresher training for all current staff will be completed by 11/22/2024. ◦ All abuse prevention policies will be reinforced during the community's monthly staff meetings. ◦ All abuse investigations will be reviewed quarterly during the community's Quality Management Meetings to ensure compliance and documentation accuracy. 4. **Monitoring to Ensure Corrections Are Sustained:** Quarterly audits of staff for abuse prevention training compliance will be conducted by the Wellness Director (WD). Additionally, all abuse investigations will be reviewed during the Quality Management Meetings each quarter to identify and address any areas of concern.	

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	Charting Note dated 06/10/24 at 7:00 PM by a Med Tech, documented R1's family came to visit R1 on this date and had a box of wine with them when they entered the Memory Care unit. The family was in R1's room for approximately 15 minutes when staff entered with the MCC. After the family left, staff found a cup of apple juice with wine in it and white residue at the bottom of the cup. The WD was notified. Hospice contacted the Social Worker, who came to the facility to check on R1 and felt R1 was not safe around R1's family. The Social Worker asked the facility not to allow family in R1's room until their investigation was done. There was no documented evidence the facility or hospice Social Worker notified APS of the staff's findings of potential abuse on 06/10/24. On 09/03/24 at 11:40 AM, the RCC reported when R1 arrived at the facility, R1 was alert. On the days the family came to visit, when the family left, R1 would be out of sorts. The family visited AM and PM, and R1 would be nonresponsive (sleeping) after the visits. R1 refused to eat the whole time at the facility, because R1 thought R1 was being poisoned. R1 would only eat ice cream and it had to be totally sealed. The facility would order it and it was delivered directly to R1 sealed. The RCC explained that on 06/10/24, the cup with R1's apple juice had an overpowering smell of wine. On 09/03/24 at 1:20 PM a Med Tech reported one time when a family member left R1's room, there was a drink that smelled like alcohol with maybe crushed pills in the cup. R1 did not want to be alone with R1's family. As of 09/03/24 in the morning, there was no documented evidence in R1's record that APS was notified for conversations and/or incidents of potential resident abuse with R1 on 06/07/24, 06/09/24 and 06/10/24. R1's record lacked documented evidence of any immediate actions taken by the facility to protect R1. On 09/03/24 in the morning, the RCC acknowledged the facility's failure to notify APS regarding R1's safety and		5. **Person(s) Responsible for Ensuring Compliance:** The Executive Director will be responsible for overseeing all corrective actions and ensuring that systemic changes are implemented. The Wellness Director and Wellness Nurse will assist in monitoring compliance and conducting audits.	

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	concerns about R1's family visiting R1. Severity: 2 Scope: 1 Complaint #NV00071699			
0885 SS= D	Medication - Destruction - NAC 449.2742 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 9. If the medication of a resident is discontinued, the expiration date of the medication of a resident has passed, or a resident who has been discharged from the facility does not claim the medication, an employee of a residential facility shall destroy the medication, by an acceptable method of destruction, in the presence of a witness and note the destruction of the medication in the record maintained pursuant to NAC 449.2744. Inspector Comments: Based on document review, record review and interview, the facility failed to destroy discontinued medications for a resident, per the requirement. (Resident #1) Findings include: Resident #1 (R1) R1 was admitted on 05/31/24 with primary diagnoses including depression, dementia, vertigo, pruritis, senile degeneration of the brain, liver cancer, hypertension and muscle weakness. The Ultimate User Agreement for R1 was signed by the Power of Attorney on 05/15/24, which gave the facility permission to possess and administer medications for R1. The Physician's Supplemental Order dated 06/03/24, documented R1 was not eating and was declining. The physician discontinued 27 of R1's medications. Medications discontinued by R1's physician on 06/03/24 included: Amlodipine, Benadryl Gel, Buspirone, Carvedilol, Celecoxib, Eliquis, Memantine, Multivitamin, Sertraline, Vitamin B, Vitamin D3, Calmoseptine, Dicyclomine, Fluticasone, Glycerin, Guaiasorb, Loperamide, Meclizine, Polyethylene Glycol and Salonpas. There was no documented evidence the facility destroyed R1's medications per the requirement, after the	0885	**Plan of Correction: Medication Destruction (Tag 0885)** 1. **Corrective Action for Affected Residents:** The Wellness Director and medtech staff will immediately ensure the proper disposal of all expired, unused, or discontinued non-narcotic and narcotic medications in accordance with policy. Documentation of the disposal will be completed and reviewed by 11/22/2024. 2. **Identification of Other Potentially Affected Residents:** The Wellness Director will conduct a full audit of all resident medication carts to identify any improperly stored or expired medications. Any discrepancies will be corrected immediately, and residents potentially affected by these medications will be monitored closely for any adverse effects. 3. **Systemic Changes to Ensure Deficiency Will Not Recur:** ◦ A detailed in-service training on medication destruction procedures will be completed by 11/22/2024 for all medtechs and Resident Care Coordinators (RCCs). ◦ The Wellness Director will conduct one-on-one and group training with medtech staff at shift changes and reinforce the importance of following medication disposal policies. ◦ Additional education will be provided during the all-staff meeting on 11/22/2024 to ensure compliance with regulatory requirements.	10/22/2024

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	medications were discontinued by the physician on 06/03/24. A Facility Charting Note dated 06/04/24 at 10:27 AM, documented facility staff gave R1's discontinued medications from the facility to R1's family member on 06/03/24. On 09/03/24 in the morning, the Resident Care Coordinator (RCC) explained it was the facility's practice to always give family members a resident's discontinued medications and was unaware of the regulatory requirement. On 09/03/24 at 1:20 PM, a Medication Technician (Med Tech) reported R1's medications were discontinued and given to R1's family member. The facility's Permanent Discontinuance MED 08 policy (revised 08/11/16), documented permanently discontinued medication will not be retained in the community ... To properly dispose of permanently discontinued medications the on duty Med Tech or RCC and another adult witness who is not a resident returns the medication to the dispensing pharmacy for disposal; or disposes of the medication in a medical waste receptacle ... The RCC or Med Tech on duty and witness will document destruction of medications on the Medication Disposition Record. Severity: 2 Scope: 1		◦ Resident Care Coordinators were educated on the regulatory requirements and our policy and procedure for medication destruction on 11/22/2024, addressing the findings in the Statement of Deficiencies (SOD) that indicated a lack of awareness. 4. **Monitoring to Ensure Corrections Are Sustained:** Monthly audits of medication carts and logs will be conducted by the Wellness Director and Wellness Nurse to monitor compliance with medication destruction policies. The medication logs will track medication destruction activities and will be reviewed during monthly staff meetings to ensure that proper procedures are followed. 5. **Person(s) Responsible for Ensuring Compliance:** The Wellness Director, Wellness Nurse, and Executive Director will be responsible for ensuring compliance with the medication destruction policy. They will work together to oversee the audits and ensure timely disposal of all medications.	