Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	9018	A. BUILDING _____ B. WING _____	01/22/2026

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

(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
RFG 0001-Deficiencies	The Statement of Deficiencies was generated as a result of a state licensure survey conducted in your facility, in accordance with Nevada administrative code, chapter 449, and Nevada revised statutes chapter 449- Residential Facility for Groups (RFG), medical facilities and other related entities. The findings and conclusions of any investigation by the Division of Health Care Purchasing and Compliance shall not be construed as prohibiting any criminal civil investigation, actions or other claims for reliefs that may be available to any party under applicable federal, state or local law. Based on an inspection conducted, the items marked below identify the violation in operation of the RFG which must be corrected by the revisit/compliance date specified in writing by the health authority. Failure to comply with this notice and immediately correct the identified deficiencies may result in the suspension or termination of your provider agreement, funding, or future authorization as a provider authorized by the State	RFG 0001-Deficiencies		

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	of Nevada pursuant to NAC 433.384, and other applicable local and state laws. Inspector Comments: This Statement of Deficiencies was generated as a result of a Complaint Investigation completed at your facility on 01/22/26. The census at the time of the survey was 154. The sample size was five. The facility received a grade of A. There were two complaints investigated. Substantiated: 1. Complaint #NV00012649 was substantiated. (See Tag 0393) Unsubstantiated: 2. Complaint #NV000512652 could not be substantiated. No regulatory deficiencies could be identified. The investigation of the Complaint included: Observations of staff assisting residents, call bells, staffing, medication administration. Interviews were conducted with residents, Caregivers, Medication Technicians, and the Wellness Directo. Record Review of resident files, which included the resident of concern. Document Review included facility policy and procedures and the Medication Administration Record.			

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Y 0393 SS= F	**NAC 449.226** **Safety requirement: Auditory systems for bathrooms and bedrooms –More than 10 residents** 4. In a residential facility with more than 10 residents: (a) Each resident must be provided with, or the bedroom and bathroom of each resident must be equipped with, an auditory system that is monitored by a member of the staff of the facility. (b) An auditory system must be available for use in the bathroom of each resident of the facility if the facility was issued its initial license on or after January 14, 1997, so that a resident needing assistance can alert a member of the staff of the facility of that fact from the toilet and the shower. (c) A bathroom that is located in a common area of the facility must be equipped with an auditory system that is monitored by a member of the staff of the facility. Inspector Comments: Based on record review and interview, the facility failed to ensure residents' call systems were responded to in a timely manner (Resident #8). Findings include: On 01/22/26 in the morning, staffing on the Assisted Living side of the facility consisted of two Med Techs and four Caregivers. Resident #8 (R8) pressed the call bell and after 15 minutes a Caregiver had not responded.	Y 0393	R8, R4, R6, and R7's pendant call expectations were reviewed with all assisted living care staff and medication technicians. Care staff have been re-educated on call system response expectations, prioritizing resident care and assistance over non-care tasks, and communication procedures when assisting another resident. Daily observation audits of pendant call response times are being conducted on all shifts by wellness and assisted living directors. The Wellness Director and Assisted Living Director will complete daily call light audits and report findings to the Executive Director for 30 days on multiple shifts. After 30 days weekly audits will be conducted for an additional 60 days. Any staff identified as delaying the response of pendant calls will receive additional coaching and/or corrective action. Audit results will be reviewed by the Executive Director and reported in department head meetings.	03/22/2026

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	On 01/22/26 in the morning, Caregiver #4 (C4) was observed walking at the other end of the hallway down from R8's room. C4 reported R8's call bell was pending on the Caregiver's monitor. C4 indicated C4 was collecting trash and did not stop collecting trash to respond to call bells. C4 acknowledged R8's pendant was pending for over 15 minutes. C4 indicated R8 showed up in red on the monitor because it was past due. On 01/22/26 in the morning, R8 reported response times ranged from five minutes up to one hour. R8 reported staff were short staffed and assistance was not timely. On 01/22/26 in the morning, Resident #4 (R4) reported when R4 pressed the call bell for R4's family member, it could take up to an hour for staff to respond on all shifts. R4 responded staff were short staffed and although care was eventually provided, it was not provided in a timely manner. On 01/22/26 in the morning, Resident #6 (R6) reported it always took more than five minutes for staff to respond after pressing the call bell. R6 indicated the care R6 needed was always received but not in a timely manner due to insufficient staffing. On 01/22/26 in the morning, Resident #7 (R7) reported when R7 pressed the call bell, it could take up to 25 minutes for staff to come and assist. R7 indicated care was provided but not in a timely manner. On 01/22/26 in the morning, Medication Technician #1 and #2 (MT1 and MT2) reported call bells should be answered in under ten minutes. If a staff member calls in and is not replaced, it makes it difficult to respond to residents in a timely manner. On 01/22/26 in the morning, Caregiver #3 reported staff were expected to answer call			

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	bells as soon as possible, but when staffing levels were reduced, it was hard to provide care in a timely manner. On 01/22/26 in the morning, the Wellness Director reported call bells should be answered within six minutes and residents should be checked frequently. Severity: 2 Scope: 3			