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 _____	**12/04/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACIES MEMORY CARE AT SAN MARTIN	**7230 GAGNIER BOULEVARD, LAS VEGAS, NEVADA ,89113**

(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 Facility Reported Incident complaint investigation completed in your facility on 12/04/23, in accordance with Nevada Administrative Code, Chapter 449, Requirements for Residential Facilities for Groups. The facility is licensed for 50 Residential Facility for Group beds for elderly and disabled persons and/or persons with Alzheimer's disease which provide Assisted Living services, Category II residents. The census at the time of the survey was 23. The facility received a grade of A. The sample size was five. There was one Facility Reported Incident (FRI) investigated. Verified with deficient practice (See TAG 0967): 1. FRI #9015 The investigation of the FRI included: -Tour of the facility and observations of audible alarms on each exit door. -Interviews were conducted with the Administrator, Resident Care Coordinator, Med Tech and two Caregivers. -Clinical record review of five residents, including the Resident of Concern. -Document review of Incident Reports and the facility elopement policy. 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.	0000		
0967 SS= D	Alzheimer’s Care - NAC 449.2754 Residential facility which provides care to persons with Alzheimer ' s disease: Application for endorsement; general requirements. (NRS 449.0302) 5. The administrator of such a facility shall prescribe and maintain on the premises of the facility a written statement which includes: (c) A description of: (1) The basic services provided for the needs of residents	0967	1. Resident Care Coordinator and Executive Director will conduct additional elopement training, including how to do head counts during alarms. 2. Staff will utilize End of Shift report and Elopement Binder to keep track of completed rounds done at beginning and end of every shift. 3. All new hires continue to be trained on Elopement protocol. Resident Care	12/29/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: TORREY DONNER Title: Executive Director Date: 12/29/2023

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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	who suffer from dementia; (2) The activities developed for the residents by the members of the staff of the facility; (3) The manner in which the behavioral problems will be managed; (4) The manner in which the medication for residents will be managed; (5) The activities that will be developed by the members of the staff of the facility to encourage the involvement of family members in the lives of the residents; and (6) The steps the members of the staff of the facility will take to: (I) Prevent residents from wandering from the facility; and (II) Respond when a resident wanders from the facility; Inspector Comments: Based on observation, document review, record review and interview the facility failed to ensure the processes and procedures for elopement were followed for a resident who eloped from the facility. (Resident #1) Findings include: Resident #1 (R1) R1 was admitted to the facility on 06/16/23 with a diagnosis of dementia. A Facility Incident Report dated 10/21/23 documented R1 eloped from the facility at 5:00 AM. R1 was found at the grocery store across the street from the facility. Paramedics came to the grocery store and transported R1 to the hospital where no injuries were reported. At 7:00 AM the facility was notified R1 was at the hospital after being located at a grocery store. Documentation review revealed on the day of the incident, the Resident Care Coordinator asked E6 if E6 was aware that R1 was not in the building and if E6 had done rounds before leaving. E6 reported not being aware of the location of R1 and had not done rounds with the oncoming shift. E6 additionally reported the alarms went off during E6's shift, but E6 did not see anyone leaving the building. There was no documented evidence E6 conducted a head count or completed a systematic search of the property after hearing the facility alarm sound. At the end of E6's shift on 10/21/23, E6 was not aware R1 had left the building		Coordinator does re-training monthly. 4. Resident Care Coordinator and Executive Director. 5. 01/03/2023 6. See attached.	

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	and did not complete rounds with the oncoming shift. A Facility Corrective Action report dated 10/21/23 documented E6 failed to conduct rounds with the oncoming shift. When asked about R1, E6 failed to know the location of R1 and did not know R1 was missing during shift change. E6 failed to conduct rounds, complete a head count, and do a systematic search of the property. A Facility Separation Form dated 10/24/23 documented E6 was terminated from the facility for a violation of company policy and procedure and not eligible for rehire. On 12/07/23 at 09:24 AM, the Resident Care Coordinator indicated the facility had a process to ensure all residents were accounted for when a door alarm to the memory care unit went off. The Resident Care Coordinator explained it was each employee's responsibility to conduct a head count and complete a systematic search of the property to ensure a resident had not eloped. To further ensure all residents were accounted for, at each shift change, employees were to complete rounds with the oncoming shift. The Resident Care Coordinator reported employees were trained on this process and procedure in the elopement training provided by the facility. The Resident Care Coordinator further acknowledged that E6 received a written reprimand for failing to conduct a head count of all residents and systematic search of the property after the facility alarm went off and was later terminated for violation of facility policy. The Resident Care Coordinator acknowledged E6 should have immediately conducted a head count of the residents and conducted a systematic search of the property when hearing the alarm go off. The Resident Care Coordinator acknowledged E6 additionally failed to conduct rounds with the oncoming shift. Severity: 2 Scope: 1 FRI# 9015			