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 _____	**12/23/2024**

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 12/23/24, 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 29. The facility received a grade of A. The sample size was five. There was one Facility Reported Incident (FRI) investigated. Substantiated with deficient practice (See TAG 0967): 1. FRI #10682 The investigation of the FRI included: -Tour of the facility and observations of audible alarms on each exit door. -Interviews were conducted with the Resident of Concern, Residents, 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. The following regulatory deficiency was identified:	0000		
0967 SS= D	Alzheimer’s Care - NAC 449.2754 and R043-22 Residential facility which provides care to persons with Alzheimer ' s disease: Application for endorsement; general requirements. (NRS 449.0302) 3. 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	0967	0967 Resident #1 was assessed upon their return with no adverse effects. Due to the elopement, the facility will conduct frequent checks o n Resident #1 to ensure safety. Additionally, the alarmed doors and being checked every 8 hours to ensure they are	01/13/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: CHRISTINA D PEREZ Title: Executive Director Date: 01/27/2025

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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	services provided for the needs of residents 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 behavior will be managed; (4) The manner in which 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 12/06/23 with a diagnosis of dementia. A Facility Incident Report dated 11/17/24 documented R1 eloped from the facility at 2:06 AM. R1 exited the facility by pushing out the front door. At the time of the incident, Employee #1 (E1) was in Room 100 and did not hear the door alarm. At approximately 3:00 AM, a local hospital left a voice mail for the facility indicating that R1 was in the emergency room. The Sales Director at the facility informed the Resident Care Coordinator of the voice mail at approximately 7:40 AM. The Resident Care Coordinator immediately followed up with the hospital which reported R1 was brought to the hospital by an unidentified pedestrian. Documentation review revealed on the day of the incident, the Resident Care Coordinator reviewed security footage of the incident. At 10:00 PM E1 was observed starting E1's shift and was on a phone call near the piano. From 10:00 PM to 1:00 AM, E1 remained on this phone call. At approximately 1:00 AM E1 entered room 100 and did not exit until		working properly. The Resident Care Coordinator will ensure that these frequent checks are being completed. Employee #1 no longer works at Legacies Memory Care at San Martin. An Inservice was held for all staff regarding policies and procedures for what to do when the alarm sounds to include a systematic search of the property. The Inservice also included conducting rounds at shift change including a head count and how to fill out an incident report. The Resident Care Coordinator will continue to train all employees on elopement policies and procedures. Date of Completion: 1/3/25.	

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	approximately 2:15 AM. R1 was observed exiting the facility at approximately 2:05 AM. At approximately 2:15 AM, E1 was observed turning off the door alarm that was triggered after exiting room 100. On 12/23/24 in the morning, the Resident Care Coordinator verbalized thinking E1 went in Room 100 to sleep, but was unsure. There was no documented evidence E1 completed a systematic search of the property after hearing the facility alarm sound after exiting Room 100. At the end of E1's shift on 11/17/24, E1 was not aware R1 had left the building and did not complete rounds with the oncoming shift. R1 did not complete an incident report and did not let anyone else know about the incident. A Facility Separation Form dated 11/20/24 documented E1 was terminated from the facility for a violation of company policy and procedure and not eligible for rehire due to E1 failing to conduct rounds which was listed as an essential job function on E1's job description. E1 did not investigate the sound of the alarm and instead just turned it off while returning to another room. On 12/23/24 in the morning, 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 E1 was terminated for failing to conduct a head count of all residents and failing to conduct a systematic search of the property after the facility alarm went off and E1 heard it. The			

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	Resident Care Coordinator acknowledged after E1 heard the alarm, E1 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 E1 additionally failed to conduct rounds throughout their shift and with the oncoming shift. Facility Elopement Policy dated 12/01/23 documented if an elopement occurs the following steps will be immediately initiated (b.) Begin a systematic search of the property and surrounding neighborhood. Severity: 2 Scope: 1 FRI# 10682			