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 _____	**02/07/2023**

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 complaint investigation completed in your facility on 02/08/23, in accordance with Nevada Administrative Code (NAC) 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 30. The sample size was four residents and four employees. The facility received a grade of A. There were two complaints investigated: Substantiated: 1. Complaint #NV00067383 was substantiated. See TAG Y174. 2. Complaint #NV00067531 was substantiated. See TAG Y174. The investigation of complaints included: Observation of the lunch meal, grooming and physical appearance of residents, tour of the facility, staff assisting residents with activities of daily living (ADL's), kitchen inspection, medication cart, and water temperatures in resident rooms and bathrooms. Interviews were conducted with the Administrator, the Maintenance Director, the Residential Care Coordinator, the Business Office Manager, a Medication Technician, a Caregiver, a Hospice Nurse, a Hospice Certified Nursing Assistant (CNA), and three residents. Record review of four residents and four employees. Document review included facility policies and procedures, staffing schedules, housekeeping schedules, food temperature logs, and resident rights. 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	Name: CYNTHIA MORRIS, LPN	Title: Executive Director/ RDO	Date: 03/30/2023

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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0174 SS= E	Health& Sanitation-odors-hazards-insects-dirt - NAC 449.209 Health and sanitation. (NRS 449.0302) 4. To the extent practicable, the premises of the facility must be kept free from: (a) Offensive odors; (b) Hazards, including obstacles that impede the free movement of residents within and outside the facility; (c) Insects and rodents; and (d) Accumulations of dirt, garbage and other refuse. Inspector Comments: Based on observation and interview, the facility failed to keep the premises free of hazards and insects. Findings include: On a tour of the facility on 02/07/23 in the afternoon, the water temperature was measured in 14 resident rooms. Six of the 14 resident rooms had shower or faucet water with temperature readings exceeding 110 degrees Fahrenheit. At 12:25 PM, the faucet water temperature in Room 106 was 125 degrees Fahrenheit. At 12:30 PM, the faucet water temperature in Room 107 was 124 degrees Fahrenheit. At 12:35 PM, the faucet water temperature in Room 112 was 124.7 degrees Fahrenheit. At 12:40 PM, the faucet water temperature in Room 122 was 122.9 degrees Fahrenheit. At 2:00 PM, the shower water temperature in Room 100 was 122.2 degrees Fahrenheit. At 2:05 PM, the shower water temperature in Room 102 was 121.6 degrees Fahrenheit. Additionally, in the afternoon on 02/07/23 on a tour of the facility, ants were observed in multiple areas. At 12:35 PM, ants were seen in Room 112 by the bathroom sink. At 12:36 PM, ants were observed outside of Room 112 on the floor, and coming in and out of the space beneath the floor at the baseboard. At 12:40 PM, ants were seen in the shower stall of vacant Room 113. At 12:51 PM, ants were on the hall floor outside the Recreation Room. Employee #3 (E3) observed and confirmed the presence of ants in the facility. On 2/7/23 in the afternoon, E3 and Employee #2 (E2) acknowledged the water temperatures	0174	1. We corrected this deficiency by having the MD adjust the temperature on the boiler. At All Staff meeting on 04/07/2023, all employees will be inserviced on checking temperatures and who to report to if temp too hot or cold. 2. Temperature checks done daily for 30 days then 2x weekly for 30 days, then once monthly. 3. Monthly audits will be inspected by ED and any corrections made immediately. 4. Executive Director and Maintenance Director. 5.02/08/2023 6. See attached supporting documents.	04/07/2023

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	exceeded 110 degrees Fahrenheit and agreed water at these temperatures was potentially harmful to residents. Severity: 2 Scope: 2			