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 _____	**02/25/2025**

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
0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation initiated at your facility on 01/28/25 and completed on 02/25/25, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facilities for Groups. The census at the time of survey was 153. The sample size was three. The facility received a grade of A. One complaint was investigated. Unsubstantiated: 1. Complaint number NV00072932 could not be substantiated. The investigation into the complaint included: Observations of meal service, resident care services and interactions between residents and staff. Interviews with residents, Caregivers, kitchen staff, Administrator, Memory Care Coordinator, Wellness Director and Home Health agency representatives. Clinical Record Review of residents, including the resident of concern. Document Review of facility Staffing Schedule, policies and procedures on Activities of Daily Living Services, Change in Condition, Monitoring/Check Protocol, Outside Agency Work with resident, Meals/Hydration/Food Choices, Incontinent Care 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 investigation, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. No regulatory deficiencies were identified. No further action required. Keep a copy for your records.	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: Title: Date:

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.