STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295052	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Las Vegas	6151 Vegas Drive Las Vegas, NV 89108

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and document review, the facility failed to ensure a care plan was revised after a resident elopement for 1 of 31 sampled residents (Resident 167). The deficient practice placed the resident at risk for inappropriate care, supervision, and accidents. Findings include: Resident 137 (R137) R137 was originally admitted to the facility on [DATE] with diagnoses including seizures, epilepsy, autistic disorder, schizophrenia, and anxiety disorder. A Nursing Progress Event Note dated 11/03/2024 at 7:10 PM, revealed the nurse was giving medications when R137 approached the nurse to call their mother around 8:00 PM. The note revealed the following information: At around 8:10 PM the CNA opened the front door remotely for a resident family member and the family member advised there was a resident outside wearing a red shirt. The CNA went outside to check and found R137 in the street in front of the building to the right. The CNA called for help and three CNAs brought R137 back to the building. At 9:15 PM the nurse called the physician to get an order for a Wonder Guard. At 9:15 PM the nurse went to the resident's room and the resident was not there. Staff looked for the resident again, and another nurse found R137 outside again. The nurse and a CNA brought R137 back inside at 9:40PM. At 11:30 PM, the CNA informed the nurse could not find R137. Staff looked outside and found R137 in front of the building at the right side near the bushes. R137 had refused to allow the staff to put the Wonder Guard on their leg and became aggressive toward staff. By 1:00 AM on 11/04/2024, R137 was asleep. According to the facility's investigation documentation, there is no evening. Staff buzz in visitors remotely in the evening due to no receptionist. When the door opens, the maglock does not close the door immediately, it stays open for at least a minute. It was thought the elopement occurred when the door was opened for a visitor or a food delivery person. (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295052	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER Life Care Center of Las Vegas		STREET ADDRESS, CITY, STATE, ZIP CODE 6151 Vegas Drive Las Vegas, NV 89108	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A care plan for risk for elopement had documented R137 had an elopement. However, the care plan had not been revised with new interventions dated on or around 11/03/2024 documenting new preventative strategies to prevent future elopements. On 11/21/2024 at 7:59 AM, the Unit Manager (UM) acknowledged the care plan is the guide for how a person is taken care of in the facility and also acknowledged the current interventions had not worked in this event where R137 had eloped three times in four hours. The UM stated the care plan needs to be updated with new interventions to try to keep the resident safe in the facility. The UM acknowledged R137's care plan had not been revised with new interventions. On 11/21/2024 at 7:20 AM, the Director of Nursing (DON) revealed they would have expected new interventions to have been added to R137's care plan. A facility policy titled Comprehensive Care Plans and Revisions revised 03/02/2022 documented the facility should monitor the resident over time to help identify changes in the resident condition which may warrant an update to the person-centered plan of care. When these changes occur, the facility should review and update the plan of care to reflect the changes to care delivery to include additional interventions on existing problems.