

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295098	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER Sage Creek Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 2350 Ione Road Las Vegas, NV 89123	
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 interview, record review, and document review, the facility failed to ensure a resident's care plan was reviewed and updated following an actual fall for 1 of 2 sampled residents (Resident 2). The deficient practice placed the resident at risk for repeated falls. Findings include: Resident 2 (R2) was admitted on [DATE] and readmitted on [DATE], with diagnoses including Parkinson's dementia and history of falls. A re-admission assessment dated [DATE], revealed R2 had a brief interview of mental status (BIMS) of 11 (moderately impaired cognition), with no wandering behaviors and had fall history prior to readmission. R2's fall care plan initiated 06/13/2026, revealed R2 was at risk for falls due to unsteady gait with a goal of not experiencing a fall related to risk factors. A nurse's note dated 06/28/2026, documented emergency services came to the facility to advise staff R2 was found on the ground in a nearby shopping complex parking lot. Hospital records dated 06/28/2026, revealed R2 eloped from the facility and was found by a bystander on the ground in a shopping complex parking lot. R2 reported falling and complained of left buttocks and knee pain. A nurse's note dated 06/29/2026, revealed R2 was transported back to the facility on [DATE] at approximately 10:00 PM. The medical record lacked documented evidence R2's fall care plan was revised following a fall incident on 06/28/2026. On 07/30/2026 at 10:05 AM, the Registered Nurse (RN) assigned to R2 on the day of the fall incident indicated the fall care plan was not revised because the fall happened outside the facility. The RN indicated being uncertain on whether the fall care plan needed to be revised and deferred to the DON. On 07/30/2026 at 11:37 AM, the Director of Nursing (DON) indicated the resident's fall care plan should have been revised even if the fall happened outside the building during an elopement. On 07/30/2026 at 12:14 PM, the DON confirmed R2 was a fall risk, had a fall care plan in place and the care plan was not reviewed or updated after the resident's actual fall on 06/28/2026. The facility's Comprehensive Person-Centered Care Plan policy revised March 2022, documented assessments were ongoing and care plans were revised as information about the residents' conditions changed. Complaint 3064998		

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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and document review, the facility failed to ensure an elderly resident did not leave facility premises without supervision or authorization and post-elopement prevention measures were adequately performed for 1 of 2 sampled residents (Resident 2). The deficient practice resulted in the resident falling in a nearby shopping complex resulting in hospitalization. Findings include: Resident 2 (R2) was admitted on [DATE] and readmitted on [DATE], with diagnoses including Parkinson's dementia and history of falls. A re-admission assessment dated [DATE], revealed R2 had moderately impaired cognition, no wandering behaviors, and had a history of falls prior to admission. A nurse's note dated 06/28/2026, documented emergency medical services (EMS) came to the facility to advise staff R2 was found on the ground of a nearby shopping complex parking lot. EMS notified the facility R2's son had instructed EMS to send R2 to the hospital for evaluation. A facility transfer form dated 06/28/2026, revealed the physician was notified of R2's elopement and transfer to the hospital. Hospital records dated 06/28/2026, revealed EMS brought R2 to the emergency department after falling at a shopping complex parking lot and was complaining of left buttocks and knee pain. R2 had eloped from the skilled nursing facility because R2 wanted to take a walk. On 07/20/2026 at 8:52 AM, the receptionist demonstrated the front door locking mechanism using an overhead switch system. The receptionist explained front doors were locked by 8:00 PM after visiting hours and were unlocked at 6:30 AM when the receptionist started morning shift. The receptionist indicated R2 walked out through the front doors while the Sunday receptionist was taking routine break, and the front desk was unmanned. On 07/30/2026 at 8:48 AM, R2 sounded alert and articulate over the phone. R2 recalled walking out through the facility's front door on a Sunday using a walker because R2 did not want to be in the facility anymore and wanted to go home. R2 indicated falling on her butt and taken to the hospital. On 07/30/2026 at 8:51 AM, R2's family member indicated being out of town when the incident occurred and was notified by the facility regarding R2's elopement and eventual hospitalization. R2's family member recalled being informed R2 was able to leave the facility because there was nobody at the front desk. R2's family member stated the situation could have been worse and was totally preventable. On 07/30/2026 at 9:50 AM, the RN assigned to R2 on 06/28/2026 recalled a nurse had called in and the RN who was supposed to be the charge nurse had to work the floor. The RN confirmed no one in the facility noticed R2 was missing until EMS pounded on the South emergency exit door and informed facility staff R2 was found on the ground in a nearby shopping complex parking lot. The RN indicated R2 returned from the hospital on the evening of the same day and was placed on one-on-one supervision. On 07/30/2026 at 11:25 AM, the Director of Nursing (DON) defined elopement as a resident leaving the premises without facility knowledge and supervision. The DON confirmed R2 eloped on 06/28/2026 by walking through the front entrance door while the weekend receptionist was on routine break. The DON corroborated with the RN's account staff did not notice R2 was missing for about 45 minutes until EMS came to the facility. The DON indicated the facility had taken the following corrective actions since R2's elopement incident: One-on-one (1:1) supervision A physician order dated 06/30/2026, documented to provide R2 with 1:1 supervision to ensure that resident does not exit the facility unsupervised, every shift for exit seeking behavior until 07/06/2026 23:59. Re- evaluate necessity with provider and to continue supervision further. The medication administration record (MAR) revealed 1:1 supervision was not recorded as being provided from 07/06/2026 until R2's discharge on [DATE]. On 07/30/2026 (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 11:41 AM, the DON explained the stop date for the 1:1 supervision was 07/06/2026 so the nurse's stopped signing off on the task on 07/06/2026. The medical record lacked documented evidence of a re-evaluation was done to evaluate necessity of continued supervision with the provider. On 07/30/2026 at 11:45 AM, the DON confirmed a re-evaluation by the physician was not performed on 07/06/2026 to evaluate necessity for continued supervision for R2. The DON confirmed the 1:1 supervision was not recorded as provided on 07/07/26, 07/08/2026, 07/09/2026 until discharge 07/10/2026 because the order ended on 07/06/2026 in the absence of re-evaluation from the provider on 07/06/2026. On 07/30/2026 at 11:50 AM, the DON indicated when physician orders were confusing, nurses must clarify them with the physician which in this case the nurse could have asked the physician whether to continue or discontinue R2's 1:1 supervision since a re-evaluation was not performed. Training on Front Desk Coverage The Front Desk Coverage guidance dated 06/29/2026, revealed the front desk was to be staffed and attended at all times during operational hours. An unattended front desk removed the facility's primary point of awareness for resident movement and created an immediate safety risk for residents, visitors and staff. No staff member may leave the front desk without securing confirmed coverage. The training was mandatory for all front desk staff. On 07/30/2026 at 8:02 AM, receptionist employed for four years indicated the facility had three receptionists. Receptionist 1 worked full-time from Mondays through Fridays from 6:30 AM to 4:00 PM, Receptionist 2 worked part-time Mondays through Thursdays from 4:00 PM to 8:00 PM and Receptionist 3 worked Friday evenings and Saturdays and Sundays from 8:00 AM to 8:00 PM. According to Receptionist 1, each receptionist was given two 15-minute breaks and a 30-minute lunch break. A facility reported incident (final) report dated 06/29/2026, documented one of the action steps to be taken by the facility was to review front desk coverage protocol and re-train all front desk staff to ensure continuous reception coverage was maintained even during break periods. The in-service sign-in sheet for Front Desk Coverage - Unattended Front Desk Prevention dated 06/29/2026 had 11 staff signatures with only one receptionist on the list. On 07/30/2026 at 2:07 PM, the Administrator confirmed the facility had three receptionists and there was only one receptionist on the in-service sign-in sheet. Elopement protocol review On 07/30/2026 at 2:07 PM, the Administrator indicated elopements were never acceptable because residents' safety could not be guaranteed outside facility premises. According to the Administrator, the facility's goal was to prevent elopement using protocols which included review of elopement protocols upon hire, annually and as needed. The Administrator indicated R2's actual elopement led the facility to re-educate staff regarding elopement protocols. On 07/30/2026 at 10:19 AM, RN1 indicated not receiving re-training or elopement policy review after R2's incident. On 07/30/2026 at 10:27 AM, RN2 indicated not being in the facility when the in-services regarding elopement review were provided. On 07/30/2026 at 10:31 AM, certified nursing assistant (CNA1) could not recall being provided with an elopement policy review in-service. On 07/30/2026 at 10:35 AM, CNA2 indicated hearing about R2's elopement but did not receive formal re-training on elopement after the incident. On 07/30/2026 at 10:41 AM, CNA3 indicated the elopement policy was not reviewed with the CNA after R2's incident. On 07/30/2026 at 10:48 AM, a Licensed Practical Nurse (LPN) indicated being on vacation when elopement training was provided and was not able to attend. On 07/30/2026 at 10:54 AM, CNA4 indicated being in the facility during R2's elopement and indicated not receiving re-training on the facility's elopement policy. The Wandering and Elopement policy/Steps for Preventing Elopement training dated 06/29/2026 and 06/30/2026 had 46 staff signatures. The names of the two RNs, four CNAs and one LPN who were interviewed did not appear in the in-service sign-in sheets. On 07/30/2026 at 2:20 PM, the Administrator confirmed the facility had 77 employees and confirmed not all staff had received the elopement training. The Wandering and (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Elopement policy dated 2001, documented the facility would identify residents who were at risk for wandering and elopement. Employees who observed a resident leaving the premises would be re-directed by staff and get help from other staff if needed. When a resident was missing, initiate the elopement/missing resident protocol.FRI 3064998		