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 _____	**07/11/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA SEVILLE	**2000 N RAMPART, LAS VEGAS, NEVADA ,89128**

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0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure and complaint survey, completed at your facility on 07/11/23, in accordance with Nevada Administrative Code (NAC) Chapter 449, Requirements for Residential Facilities for Groups. The facility is licensed for 144 Residential Facility for Group beds for elderly and disabled persons and/or Assisted Living Services and/or persons with chronic illness and/or persons with mental illness, 103 Category I residents and 41 Category II residents. The census at the time of the survey was 112. Twenty-six resident files and ten employee files were reviewed. The facility received a grade of B. On 07/11/23 at 12:20 PM, an immediate jeopardy situation was identified due to the facility's failure to maintain a safe fire suppression system, placing all residents at risk for potential injury in the event of a fire emergency. See TAG 174. On 07/11/23 at 5:25 PM, the immediate jeopardy situation was abated regarding the facility's ability to temporarily repair the system and implement an hourly fire watch. There was one complaint investigated: Unverified: Complaint #NV00068062 could not be verified. No regulatory deficiencies could be identified. The investigation of the Complaint included: Observation of resident rooms and a tour of the facility, resident hygiene, residents with dentures, residents requiring incontinence care, fall precautions and interventions and supplies and location. Observation of staff monitoring residents. Interviews were conducted with the Executive Director, the Wellness Director, a Medication Technician, a Caregiver and 10 residents. Record Review of 26 records, including the resident of concern. Document Review included facility policy and procedures, including discharge and fall prevention policy and facility incident reports. The findings and conclusions of any	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: MICHAEL MASICH Title: Executive Director Date: 07/24/2023

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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	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. The following regulatory deficiencies were identified:			
0174 SS= I	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, interview, and document review, the facility failed to ensure the fire suppression and automatic sprinkler systems were functional in the event of a fire emergency. Findings include: On 07/11/23 at 9:20 AM, the automatic sprinkler system riser had a red tag dated 06/18/23, which read, "IMPAIRED. Upon arrival dry system was low on air. Turned compressor on and started making a loud knocking noise. Shut compressor off. The red tag also revealed a vendor fire alarm repair technician (technician) was notified about the impairment and the technician was to follow up with an assessment on 06/19/23. In addition, the automatic sprinkler system's riser gauge indicated 0 pressure. A Provisional Invoice / Service Request dated 06/18/23, documented upon the technician's arrival, the tamper switch for the low air-dry system was active. The technician went to the riser room where the dry system was, and found the compressor was making a popping sound. The technician closed the control valve for the dry system and shut off the power to the compressor. The technician had the facility put in an emergency service call for sprinklers to be assessed. There was no	0174	Maintenance Director and or Executive Director to continue to visually inspect Fire Riser Room during weekly inspections, and check Fire Protection Control Valves and Gages to ensure that they are operating as normal. Maintenance Director and or Executive Director will ensure all inspections and repairs are completed in a timely manner, If there is any impairment tags or Fire System is not in normal operation Maintenance Director and or Executive Director will stay in constant contact with Fire Suppression Company to ensure repairs are completed promptly, Also, Maintenance Director and or Executive Director will ensure that the community is on fire watch if Fire System is not in normal operation. We will notify the local Fire Marshal and state anytime we need to be on Firewatch and ensure we are properly documenting.	07/24/2023

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	documented evidence the facility had the air compressor and the automatic sprinkler system reassessed by the technician on 06/19/23. -On 07/11/23 at 9:20 AM, the Administrator reported the automatic sprinkler system in the attic crawl space and the external canopies, as well as twenty sprinkler heads on the second floor were not in operation. The non-operational sprinkler heads potentially affected all residents' safety because the air compressor had not been repaired timely. -At 11:00 AM, the Administrator acknowledged the facility received the vendor's invoice on 06/18/23, which documented the air compressor and automatic sprinkler system were impaired and required reassessment by the vendor. However, a reassessment and repair had not been completed as of 07/11/23. -At 11:10 AM, the Administrator confirmed the automatic sprinkler system was out of operation since 06/18/23 because an air compressor was not providing air pressure to one of three sprinkler risers responsible for sprinklers in the attic crawl space, the external canopies, and twenty sprinkler heads in the storage areas on the second floor of the facility. The facility policy Alternate Fire Control Plan, effective 09/26/13, documented the facility will institute an alternate fire control plan in the event that the fire detection, fire alarm, or sprinkler system is impaired or inoperable. The Executive Director and Maintenance Director will be notified immediately upon identification of impaired or inoperable fire detection, fire alarm or sprinkler system. A fire watch will be implemented by the Executive Director or designee: An assigned staff member walks throughout the community including all corridors, common areas, basement, laundry, and kitchen every hour. The staff member observes each area for fire hazards and signs of fire, i.e., the sight or smell of smoke or flames. The staff member who conducted the fire watch each half hour will sign off on			

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	the Fire Watch Documentation Record. The Fire Watch will continue until the systems are repaired and operational. On 07/11/23 in the morning, there was no evidence a fire watch was implemented in response to the impaired air compressor and automatic sprinkler system per the facility's policy. -At 11:15 AM, the Administrator verified there was no fire watch conducted at the facility from 06/18/23 through 07/11/23, per the facility's policy. -At 12:00 PM, the Administrator indicated contacting the vendor and the technician was scheduled to arrive at the facility on 07/11/23 in the afternoon. -At 12:20 PM, the Administrator was informed an Immediate Jeopardy was identified due to the air compressor and automatic sprinkler system not being repaired and/or the lack of an alternate fire control plan implemented at the facility. -At 2:20 PM, the Administrator and the Regional Vice President acknowledged the facility had no structured plan in place to repair the fire suppression and automatic sprinkler systems. They were unaware how long it would take for the systems to be repaired, depending on the availability of a new compressor. The Administrator and the Regional Vice President verbalized a fire watch would be initiated on 07/11/23, per the facility's abatement plan. -At 2:45 PM, a technician arrived at the facility. The technician acknowledged the lack of a functional fire suppression system, and that this posed a safety risk to residents in the event of a fire. The technician verbalized the facility had not contacted the vendor to arrange for repair of the fire suppression and automatic sprinkler system since 06/18/23. -At 3:00 PM, the local Fire Inspector provided an Inspection Report which documented a violation of the nonstandard Sprinkler System. -At 5:25 PM, the facility provided an acceptable abatement plan to the Immediate Jeopardy regarding the facility's ability to ensure temporary repair of the fire suppression and automatic sprinkler systems and implement			

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	an hourly fire watch. Severity: 3 Scope: 3			
0430	Requirements and Precautions - NAC 449.229 Requirements and precautions regarding safety from fire. (NRS 449.0302) 1. The administrator of a residential facility shall ensure that the facility complies with the regulations adopted by the State Fire Marshal pursuant to chapter 477 of NRS and all local ordinances relating to safety from fire. The facility must be approved for residency by the State Fire Marshal. 2. The Bureau shall notify the State Fire Marshal or the appropriate local government, as applicable, if, during an inspection of a residential facility, the Bureau knows of or suspects the presence of a violation of a regulation of the State Fire Marshal or a local ordinance relating to safety from fire. Inspector Comments: On 07/11/23 at 12:25 PM, a referral to the State Fire Marshal was made via telephone and electronic mail. Reference TAG 174.	0430	The administrator or designee shall ensure that the facility complies with the regulations adopted by the State Fire Marshal pursuant to chapter 477 of NRS and all local ordinances relating to safety from fire. At any time if there is a presence of a violation of a regulation of the State Fire Marshal or a local ordinance relating to safety from fire the administrator or designee will contact the State Fire Marshal or a local ordinance immediately.	07/24/2023

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0923 SS= D	Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 3. Medication, including, without limitation, any over-the-counter medication or dietary supplement, must be: (a) Plainly labeled as to its contents, the name of the resident for whom it is prescribed and the name of the prescribing physician; and (b) Kept in its original container until it is administered. Inspector Comments: Based on observation and interview, the facility failed to ensure a medication was properly labeled for 1 of 26 residents (Resident #15). Resident #15 (R15) was admitted on 12/31/22 with diagnoses including hypertension and chronic kidney disease. A bottle of Senexon-S tablets was found in the bin of R15 and did not contain the residents name, prescriber, route and directions for administration. A Medication Technician confirmed a bottle of Senexon-S was not properly labeled with the resident's name, prescriber, route and directions for administration. Severity: 2 Scope: 1	0923	Audit per Work Instruction. Teach and train to our processes, Triple Check Order Process and Med Cart Audit. (Please find attached work instructions)	07/24/2023