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 _____	**07/22/2025**

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

(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 an annual State Licensure and complaint and bed change survey, completed at your facility on 07/22/25, 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 mental illness, 103 Category I residents and 41 Category II residents. The facility has applied for a bed change and was approved to decrease the number of Category I beds from 103 to 84 beds, and to increase the number of Category II beds from 41 to 60 beds. The census at the time of the survey was 118. Twenty-five resident files and ten employee files were reviewed. The facility received a grade of A. There was one complaint investigated. Substantiated without deficient Practice: Complaint #NV00074549 was substantiated with no deficient practice. The investigation of Complaint included: Observation of residents appropriately placed in the facility, staff assisting residents and fall precautions. Interviews were conducted with residents, caregivers, a medication technician, the Director of Culinary Services, a Registered Nurse and the Executive Director. Clinical Record Review of five records, including the resident of concern. Document Review included facility policy and procedures 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. The following regulatory deficiencies were identified:	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: MARKIE HAMLIN Title: Administrator Date: 08/19/2025

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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0255 SS= D	Permits-Comply with NAC 446 on Food Service - NAC 449.217 Kitchens; storage of food; adequate supplies of food; permits; inspections. (NRS 449.0302) 6. A residential facility with more than 10 residents shall: (a) Comply with the standards prescribed in chapter 446 of NAC; and (b) Obtain the necessary permits from the Division. Inspector Comments: Based on observation on 07/22/2025, the facility failed to ensure the kitchen and supportive dining services complied with the standards of NAC 446. Findings include: 1. Major Violations: a. There was black grime and pink biofilm build-up on the internal components of the ice machine in the kitchen. Severity: 2 Scope: 1	0255	Quarterly preventive maintenance was completed on July 23rd which included cleaning and sanitizing the ice machine. At the request of the community, the vendor completing the quarterly maintenance removed internal components and cleaned and sanitized behind and around internal components. See photographs. Bi-monthly walk-thru with Executive Director and Director of Culinary services to ensure weekly cleaning checklist that address ice machine cleanliness is being completed in its entirety.	07/23/2025
0870 SS= D	Medication Administration-Accuracy & Report - NAC 449.2742 Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall: (a) Ensure that a physician, pharmacist or registered nurse who does not have a financial interest in the facility: (1) Reviews for accuracy and appropriateness, at least once every 6 months the regimen of drugs taken by each resident of the facility, including, without limitation, any over-the-counter medications and dietary supplements taken by a resident; and (2) Provides a written report of that review to the administrator of the facility. (b) Include a copy of each report submitted to the administrator pursuant to paragraph (a) in the file maintained pursuant to NAC 449.2749 for the resident who is the subject of the report. (c) Make and maintain a report of any actions that are taken by the caregivers employed by the facility in response to a report submitted pursuant to paragraph (a).	0870	Complete audit of 6-month med reviews for all residents on Atria’s Medication Management Program was done post survey. 6-month medication reviews have been signed by the Executive Director. Comprehensive tracker will be utilized by the Executive Director, Resident Services Director and Resident Services Coordinator to ensure compliance. Monthly review of tracker with Resident Services Director and Executive set for the 3rd Thursday of every month. Tracker has been uploaded. Resident20 and resident 23 med reviews have been uploaded. Resident 14 med review has been requested from PCP.	08/18/2025

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	Inspector Comments: Based on record review and interview, the facility failed to ensure medication reviews were conducted every six months for 2 of 25 residents (Residents #14, and #20), and the facility failed to ensure six month medication reviews were reviewed and initialed by the Administrator for 3 of 25 residents (Residents #14, #20, and #23). Findings include: Resident #14 (R14) R14 was admitted on 06/30/24 with diagnoses including hypertension and congestive heart failure. R14's resident file documented a six month medication review dated 12/07/24 and the medication review lacked evidence of the Administrator's review and initials. R14's resident file lacked evidence of a current six month medication review. Resident #20 (R20) R20 was admitted on 09/20/22 with diagnoses including stroke and cognitive dysfunction. R20's resident file documented a six month medication review dated 11/06/24 and the medication review lacked evidence of the Administrator's review and initials. R20's resident file lacked evidence of a current six month medication review. Resident #23 (R23) R23 was admitted on 03/31/23 with diagnoses including hypertension and congestive heart failure. R23's resident file documented six month medication reviews dated 03/05/25 and 05/22/25. The medication reviews lacked evidence of the Administrator's review and initials. On 07/22/25 in the afternoon, the Administrator acknowledged six month medication reviews were not conducted every six months for R14 and R20, and the Administrator acknowledged six month medication reviews were not initialed for R14, R20, and R23. Severity: 2 Scope: 1			

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0936 SS= D	Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he or she permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including, without limitation: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. Inspector Comments: Based on interview and record review, the facility failed to ensure an initial two step tuberculosis (TB) screening was completed for 1 of 25 residents (Resident #3) and an annual TB screening was completed for 1 of 25 residents (Resident #14). Findings include: Resident #3 (R3) R3 was admitted on 11/18/24 with diagnosis including cerebral vascular accident and hypertension. Review of R3's medical record revealed R3 completed a TB screening on 11/18/24. R3's medical record lacked documented evidence a second step TB was completed. Resident #14 (R14) R14 was admitted on 06/30/24 with diagnosis including chronic heart failure and hypertension. Review of R14's medical record revealed R14 completed a chest x-ray negative for TB on 06/26/24. R14's medical record lacked documented evidence of an annual TB test. On 07/22/25, in the morning, the Executive Director confirmed a two-step TB screening was not completed for R3 and a annual TB screening was not completed for R14. Severity: 2 Scope: 1	0936	TB Clinic was held 7/24/2025 and 2more TB clinics have been scheduled for September 2025 and December 2025. Monthly review of TB tracker with Resident Services Director and Executive set for the3rd Thursday of every month. Tracker has been uploaded. Resident #3TB record uploaded. Resident #14 TB screening appointment record has been uploaded.	08/18/2025