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 _____	**04/04/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PACIFICA SENIOR LIVING SPRING VALLEY	**8880 W TROPICANA AVE, LAS VEGAS, NEVADA ,89147-6000**

(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 Survey, infection control survey, and Complaint Investigation conducted at your facility on 04/04/23, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 72 Residential Facility for Group beds for elderly and disabled persons and/or persons with Alzheimer's disease, with an endorsement for Assisted Living, Category II residents. The census at the time of the survey was 56. Fifteen resident records and ten employee records were reviewed. The facility received a grade of A. There was one complaint investigated. Unsubstantiated: Complaint #NV00067928 could not be substantiated. No regulatory deficiencies could be identified. The investigation of the Complaint included: Observation of the alertness of residents, resident and Caregiver interaction at meals, the lunch service, and facility visitors. Interviews were conducted with residents, Caregivers, the Medication Technician, the Administrator, the Kitchen Manager, and the Resident Services Coordinator. Record review of six resident files, which included the Resident of Concern's file. Document review included menus and Medication Administration Records. 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 investigations, 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: DONALD TRUMP Title: Executive Director Date: 05/05/2023

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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0255 SS= E	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 04/04/2023, the facility failed to ensure the kitchen and supportive dining services complied with the standards of NAC 446. Findings include: 1. Critical Violations: a. In the walk-in cooler, two containers of cottage cheese were expired on 04/01/23. 2. Major Violations: a. There was dust build-up behind the equipment on the cook's line and on the fan guard of the evaporator in the walk-in cooler. b. There was black build-up on the wall near the dish machine. 3. Equipment and Maintenance Violations: a. The Fiberglass Reinforced Panels (FRP) on the wall entering the ware washing area were separating from the wall and the corner guards were in disrepair. b. There was dust build-up around the ceiling air vents. Severity: 2 Scope: 2	0255	1. Critical Violations A) Kitchen staff removed expired containers and threw them out. Kitchen staff called Sysco and reported delivery of outdated cottage cheese. B) Assigned kitchen staff designated to double check each delivery to ensure that dates are not expired on delivery. An in-service completed for daily check in the walk in cooler. C) Dietary Manager D) 4/4/23. E) In-service sheet enclosure A. 2. Major Violations A) Built-up behind the equipment on the cook line and fan guard of the evaporator of the walk in cooler and freezer was cleaned. B) Weekly inspection and cleaning log in place. C) Maintenance Supervisor / Dietary Manager. D) 4/5/23 E) Weekly inspection and cleaning log enclosure B, enclosure H, enclosure I, and enclosure J. 3. Black built up on wall by dish machine A) Cleaned black built up by the wall. B) The fore mentioned cleaning log will include this area as well. C) Maintenance Supervisor / Dietary Manager. D) 4/05/23. E) Copy of inspection and cleaning log enclosure B. enclosure C. enclosure D 4. Equipment and Maintenance Violations A) Fiber Glass Reinforced panels repaired and corner guards replaced. B) Wall wear and tear will be observed using the fore mentioned weekly inspection schedule. C) Maintenance Supervisor / Dietary Supervisor. D) 04/5/23 E) Copy of weekly inspection and Cleaning Log enclosure B, enclosure E. 5. Equipment and Maintenance Violations A) All ceiling air vents removed and cleaned. B) Vents will be observed using fore mentioned weekly inspection and cleaning log. C) Maintenance Supervisor / Dietary Supervisor. D) 4/5/23. E) enclosure B, enclosure F, enclosure G	05/05/2023

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0999 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 Residential facility which provides care to persons with Alzheimer ' s disease: Standards for safety; personnel required; training for employees. (NRS 449.0302) 1. The administrator of a residential facility which provides care to persons with Alzheimer ' s disease shall ensure that: (g) All toxic substances are not accessible to the residents of the facility. Inspector Comments: Based on observation and interview, the facility failed to ensure toxic substances were inaccessible to residents living in the Memory Care Unit. Findings include: On 04/04/23 at 10:00 AM, during a tour of the facility, a can of Lysol spray and Bleach disinfectant cleaner were observed inside an unsecured cabinet in the Memory Care dining room. On 04/04/23 at 10:00 AM, the Maintenance Supervisor confirmed the above items located in the Memory Care dining room cabinet were not secured. Severity: 2 Scope: 3	0999	A) Toxic substances were removed from the cabinet in the pantry. Access door is locked and posted with a locked sign. B) Weekly inspections will be done using the fore mentioned weekly inspection and cleaning log. enclosure B. C) Maintenance Supervisor / Dietary Manager D) 5/4/23 E) Enclosure K	05/05/2023

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1540 SS= F	Cultural Competency Training - R016-20 Section 14.1 1. Pursuant to subsection 1 of NRS 449.103, within 30 business days after the course or program is assigned a course number by the Division pursuant to section 18 of this regulation or within 30 business days of any agent or employee being contracted or hired, whichever is later, and at least once each year thereafter, a facility shall conduct training relating specifically to cultural competency for any agent or employee of the facility who provides care to a patient or resident of the facility so that the agent or employee may: (a) More effectively treat patients or care for residents, as applicable; and (b) Better understand patients or residents who have different cultural backgrounds, including, without limitation, patients or residents who fall within one or more of the categories in paragraphs (a) to (f), inclusive, of subsection 1 of NRS 449.103. Inspector Comments: Based on interview and record review, the facility failed to ensure 6 of 10 employees (Employee #1, Employee #2, Employee #5, Employee #6, Employee #7 and Employee #8) were in compliance with Nevada Revised Statues (NRS) 449.103, regarding cultural competency training. There was no documented evidence Cultural Competency training for Employee #1, #2, #5, #6, #7 and #8 was completed from an approved program. The Business Office Manager confirmed Cultural Competency training was not completed for Employee #1, #2, #5, #6 #7 and #8. Severity: 2 Scope: 3	1540	A) An authorized trainer has been obtained for training. B) Employee no. 1, 2, 5, 6, 7, 8 are scheduled for training from this vendor. C) Executive Director / Business Office Manager D) 05/19/23. E) Enclosure L, enclosure M, enclosure N, and enclosure O.	05/05/2023