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 _____	**09/16/2025**

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 a complaint investigation and Facility Incident Report investigation completed in your facility on 09/16/25, in accordance with Nevada Administrative Code (NAC), Chapter 449, Residential Facilities for Groups. The census at the time of the survey was 56. The sample size was five. The facility received a grade of A. There were three complaints and one Facility Reported Incidents (FRI) investigated. Substantiated without deficient practice. 1. Complaint #NV00074734 was substantiated with no deficient practice. 2. Complaint #NV00074609 was substantiated with no deficient practice. 3. FRI #11645 was substantiated without deficiencies. Unsubstantiated: 4. Complaint #NV00074714 could not be substantiated. No regulatory deficiencies could be identified. The investigation of Complaints and FRIs included: Observation of physical appearance for residents, medication administration, hygiene care and residents positioning in bed. Interviews were conducted with a Med Tech, a Caregiver, the Administrator and residents. Clinical record review of five records, which included the residents of concern. Document Review included facility policy and procedures, staffing schedule, intake documentation. 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. There were no deficiencies identified. Maintain a copy for your records.	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: Title: Date:

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.