STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2758	A. BUILDING _____ B. WING _____	11/10/2025

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
RFG 0001-Deficiencies	The Statement of Deficiencies was generated as a result of a state licensure survey conducted in your facility, in accordance with Nevada administrative code, chapter 449, and Nevada revised statutes chapter 449- Residential Facility for Groups (RFG), medical facilities and other related entities. The findings and conclusions of any investigation by the Division of Health Care Purchasing and Compliance shall not be construed as prohibiting any criminal civil investigation, actions or other claims for reliefs that may be available to any party under applicable federal, state or local law. Based on an inspection conducted, the items marked below identify the violation in operation of the RFG which must be corrected by the revisit/compliance date specified in writing by the health authority. Failure to comply with this notice and immediately correct the identified deficiencies may result in the suspension or termination of your provider agreement, funding, or future authorization as a provider authorized by the State	RFG 0001-Deficiencies		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2758	A. BUILDING _____ B. WING _____	11/10/2025

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
	of Nevada pursuant to NAC 433.384, and other applicable local and state laws. Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint and Facility Incident Report investigation initiated at your facility on 09/16/25 and completed 11/10/25, in accordance with Nevada Administrative Code (NAC), Chapter 449, Residential Facilities for Groups. The census at the time of the survey was 53. The sample size was five. The facility received a grade of A. There was one complaint and two Facility Reported Incidents (FRI) investigated. Substantiated: 1. Complaint #NV00012261 was substantiated (See TAG 878). 2. FRI #11945 was substantiated (See TAG 50). 3. FRI #12344 was substantiated (See TAG 965). The investigation of the Complaint and FRIs included: Observation of grooming and physical appearance for residents, the environment, resident behaviors, and a tour of the facility. Interviews were conducted with residents (attempted), the Administrator, a Medication Technician and a Dentist from a local dentist's office. Clinical Record Review of 5 records, which included the residents of concern.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2758	A. BUILDING _____ B. WING _____	11/10/2025

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
	Document Review included facility policy and procedures and incident reports.			
Y 0050 SS= G	**NAC 449.194** **Responsibilities of administrator.** The administrator of a residential facility shall: 1. Provide oversight and direction for the members of the staff of the facility as necessary to ensure that residents receive needed services and protective supervision and that the facility is in compliance with the requirements of NAC 449.156 to 449.2766, inclusive, and chapter 449 of NRS. Inspector Comments: Based on interview and record review, the facility failed to ensure there was adequate supervision to prevent a resident from eloping from the facility for 1 of 5 sampled residents. (Resident #1). Findings include: Resident #1 (R1) R1 was admitted to the facility on 06/06/25 with a diagnosis of dementia. R1's care plan dated 06/05/25 documented R1, was assessed as an elopement risk and required moderate level of supervision. The care plan lacked documented evidence as to what measures staff were required to provide for a resident who was determined to require a moderate level of supervision. Incident report dated 07/14/25 documented	Y 0050	1)How you will correct the specific finding(s) stated in the Statement ofDeficiencies (MUST ADDRESS); Stafftraining conducted on 10/3/2025 regarding elopement policy and procedure andall staff instructed regarding supervision of residents with high risk ofelopement and supervision of facility exit doors R1 wasreassessed for elopement risk on 10/3/2025 and all staff have been trained regardingher person-centered care plan needs. 2) What measures or systematic change(s) will be put intoplace to ensure the deficient practice does not recur (MUST ADDRESS); Stafftraining conducted on 10/3/2025 regarding elopement policy and procedure andall staff instructed regarding supervision of residents with high risk ofelopement and supervision of facility exit doors. All new staff to receive additionaltraining regarding careplan needs, and resident supervision 3) How the corrective action(s) will be monitored to ensurethe deficient practice will not recur (MUST ADDRESS); Manager onduty each day with check exits to ensure they are secure, and all residents areaccounted for. 4) The title of the person (position) responsible forensuring the plan of correction is implemented Administrator, Director ofWellness, Maintenance Director	10/03/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2758	A. BUILDING _____ B. WING _____	11/10/2025

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
	R1 eloped from the facility on 07/14/25. R1 exited out of the building and was able to go next door to a dental office where R1 was allowed entry by the cleaning staff. The dental office staff called the police, and police arrived at the dental office at approximately 7:35 PM. The police identified where R1 resided and brought R1 back to the facility at approximately 7:47 PM. When R1 was brought back to the facility, staff escorted R1 back to their room where a head-to-toe assessment was completed. R1 received no harm from the incident, and the R1's responsible party was notified. R1's care plan was updated to reflect R1 was a high elopement risk dated 07/18/25. R1's new elopement risk assessment dated 07/18/25, documented R1 was not able to exit the facility without notifying staff. Staff were instructed to monitor R1 more closely, when they would notice R1 having the behavior of walking around the building looking for their kids. This plan was put in place on 07/18/25 after R1's documented elopement and would be in place while R1 was in the facility. On 11/10/25 in the morning, the caregivers currently at the facility were not employed at the facility the night R1 eloped and could not explain how R1 exited the facility on 07/14/25. On 11/10/25 in the morning, the current Administrator reported this elopement happened prior to being the Administrator. The only documented evidence the current Administrator had was the incident report and could not speak to what the previous Administrator had in place to keep R1 from eloping. The current Administrator explained by reviewing the incident report they determined the facility staff at the time were unaware R1 was missing from the facility on 07/14/25. The Administrator explained the current staff had no knowledge of how R1 exited the facility on 07/14/25. The Administrator reported that the facility was endorsed to care for individuals diagnosed with Alzheimer's		5) The date the corrective action will be completed 10/3/2025 6) You must attach all supporting documents into the system(MUST INCLUDE).	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2758	A. BUILDING _____ B. WING _____	11/10/2025

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
	Disease and other forms of dementia and the expectation should have been that the facility was to maintain a secure building to prevent residents from leaving the facility unattended. On 11/10/25, in the afternoon, the Dentist from the dentist office next door to the facility, reported on 07/14/25 they were at the dental office later than usual due to a patient needing a late appointment. The Dentist was expecting the patient's family members to come to the office to pick up the patient. The cleaning staff opened the door at 5:05 PM when the family members arrived. R1was with the family members waiting outside and went into the dental office with the patient's family members. The Dentist realized R1 was not related to the patient's family members and was not aware of where R1 had come from until someone explained R1 could be from the Assisted Living facility next door. Around 5:15 PM the Dentist called 911 to have police come and take R1 back to the facility. The Dentist reported the police arrived at 7:35 PM and left with R1 at 7:45 PM. There was no indication staff from the facility had come to look for R1. There was no documented evidence that the facility was aware R1 had eloped from the facility on 07/14/25 until the police brought R1 back to the facility. R1's file documented R1 eloped again with another resident on 10/02/25. Severity: 3 Scope: 1 FRI# 11945			
Y 0965 SS= F	NAC 449.2754	Y 0965	1) How you will correct the specific finding (s) stated inthe Statement of Deficiencies (MUST ADDRESS);	12/20/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2758	A. BUILDING _____ B. WING _____	11/10/2025

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
	Residential facility which provides care to persons with Alzheimer's disease: Application for endorsement; general requirements. 3. The administrator of such a facility shall prescribe and maintain on the premises of the facility a written statement which includes: (a) The facility's policies and procedures for providing care to its residents; (b) Evidence that the facility has established interaction groups within the facility which consist of not more than six residents for each caregiver during those hours when the residents are awake; (c) A description of: (1) The basic services provided for the needs of residents who suffer from dementia; (2) The activities developed for the residents by the members of the staff of the facility; (3) The manner in which behaviors will be managed; (4) The manner in which medication for residents will be managed; (5) The activities that will be developed by the members of the staff of the facility to encourage the involvement of family members in the lives of the residents; and (6) The steps the members of the staff of the facility will take to: (I) Prevent residents from wandering from the facility; and (II) Respond when a resident wanders from the facility; and (d) The criteria for admission to and discharge and transfer from the facility.		Stafftraining conducted on 10/3/2025 regarding elopement policy and procedure andall staff instructed regarding supervision of residents with high risk ofelopement and supervision of facility exit doors R1 and R3 werereassessed for elopement risk on 10/3/2025 and all staff have been trained regardingher person-centered care plan needs. Emergency binderwill be developed with current resident pictures and all emergency informationby 12/20/2025 2) What measures or systematic change(s) will be put intoplace to ensure the deficient practice does not recur (MUST ADDRESS); Stafftraining conducted on 10/3/2025 regarding elopement policy and procedure andall staff instructed regarding supervision of residents with high risk ofelopement and supervision of facility exit doors. All new staff to receive additionaltraining regarding careplan needs, and resident supervision 3) How the corrective action(s) will be monitored to ensurethe deficient practice will not recur (MUST ADDRESS); Manager onduty each day with check exits to ensure they are secure, and all residents areaccounted for. 4) The title of the person (position) responsible forensuring the plan of correction is implemented Administrator, Director ofWellness, Maintenance Director 5) The date the corrective action will be completed 12/20/2025 6) You must attach all supporting documents into the system(MUST INCLUDE).	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2758	A. BUILDING _____ B. WING _____	11/10/2025

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
	4. The written statement required pursuant to subsection 3 must be available for review by residents of the facility, members of the staff of the facility, visitors to the facility and the bureau. 5. The administrator shall ensure that the facility complies with the provisions of the statement required pursuant to subsection 3. Inspector Comments: Based on document review, record review and interview, the facility failed to ensure there was a plan in place during an emergency at the facility to prevent residents from eloping out an unsecured front door. Findings include: Resident#1 (R1) R1 was admitted to the facility on 06/11/25 with a diagnosis of Alzheimer's disease. R1's file documented a previous elopement on 07/14/25. R1's elopement risk assessment dated 07/18/25, documented R1 was not able to exit the facility without notifying staff. Staff were instructed to monitor R1 more closely, when they would notice R1 having the behavior of walking around the building looking for their kids. This plan was put in place on 07/18/25 after R1's documented elopement and would be in place while R1 was in the facility. Resident#3 (R3) R3 was admitted to the facility on 08/27/25 with a diagnosis of Alzheimer's disease. A Facility Incident Report dated 10/02/25 documented at 11:00 PM R1 was walking around with R3. The facility was in the middle of an emergency on the side of the facility named Field side which led to the doors being left open. A caregiver noticed			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2758	A. BUILDING _____ B. WING _____	11/10/2025

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
	R1 and R3 were not in the facility. The caregiver and four other staff double checked all rooms and could not locate R1 and R3. Facility staff reported R1 and R3 went out the front door while emergency crews and police were in the building. Staff informed the police that R1 and R3 were missing. Just after the police were notified by staff, R1 and R3 were found outside the building, the Administrator was notified. R1 and R3 were found down the street on the corner of Tropicana and Durango by Metro Police. R1 and R3 were assumed to be missing for approximately ten to fifteen minutes. Facility narrative reporting revealed that on the day of the incident dated 10/02/25, the facility had a medical emergency, and the front doors were left open by Emergency Crews that allowed R1 and R3 to elope from the facility through the front door. There was no documented evidence staff, or a receptionist were stationed at the open unalarmed doors to ensure residents did not elope. On 11/10/25 in the morning, the Administrator explained it was determined R1 and R3 had eloped through those open doors since they were the only doors open and unalarmed. On11/10/25 in the morning, the receptionist verbalized the facility did not have a written plan of what to do in a situation where there was an emergency in the building to prevent residents from eloping while the doors were not secured. The receptionist verbalized that the facility did not have a picture or policy binder at the front desk to recognize residents who have a history of elopement. Facility Elopement Management policy undated documented If warranted, complete a Missing Resident Detailed Profile, including a resident photo for each of these residents and include it in an Unsupervised Absence binder. Update annually or if a change occurs.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2758	A. BUILDING _____ B. WING _____	11/10/2025

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
	Severity: 2 Scope: 3 FRI #12344			
Y 0878 SS= D	**NAC 449.2742** 5. An over-the-counter medication or a dietary supplement may be given to a resident only if the resident's physician , physician assistant or advanced practice registered nurse has approved the administration of the medication or supplement in writing or the facility is ordered to do so by another physician , physician assistant or advanced practice registered nurse. The over-the-counter medication or dietary supplement must be administered in accordance with the written instructions of the physician , physician assistant or advanced practice registered nurse. The administration of over-the-counter medications and dietary supplements must be included in the record required pursuant to paragraph (b) of subsection 1 of NAC 449.2744. 6. Except as otherwise provided in this subsection, a medication prescribed by a physician, physician assistant or advanced practice registered nurse must be administered as prescribed by the physician, physician assistant or advanced practice registered nurse.. If a physician, physician assistant or advanced practice registered nurse orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order; (2) Indicate on the container of the medication that a change has occurred; and (3) Note the change in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; (b) Within 5 days after the change is ordered, a copy of the order or prescription	Y 0878	1) How you will correct the specific finding (s) stated inthe Statement of Deficiencies (MUST ADDRESS); R2 wasevaluated following medication error by EMS. Disciplinary action was taken againstemployee who made error. RP and PCP notified, and state report completed. 2) What measures or systematic change(s) will be put intoplace to ensure the deficient practice does not recur (MUST ADDRESS); Stafftraining conducted with medication technicians on 11/20/2025 Regarding theproper administration of medication. 3) How the corrective action(s) will be monitored to ensurethe deficient practice will not recur (MUST ADDRESS); Quarterlycart audits and daily checks of medication administration record to ensureerrors are corrected. 4) The title of the person (position) responsible forensuring the plan of correction is implemented Administrator and Director ofWellness 5) The date the corrective action will be completed 11/20/2025 6) You must attach all supporting documents into the system(MUST INCLUDE).	11/20/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2758	A. BUILDING _____ B. WING _____	11/10/2025

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
	signed by the physician, physician assistant or advanced practice registered nurse must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744; and (c) If the label prepared by a pharmacist does not match the order or prescription written by a physician, physician assistant or advanced practice registered nurse, a physician, registered nurse or pharmacist must interpret that order or prescription and, within 5 days after the change is ordered, the interpretation must be included in the record maintained pursuant to paragraph (b) of subsection 1 of NAC 449.2744. Inspector Comments: Based on record review and staff interview, the facility failed to ensure medications were administered as ordered, and to ensure the medication was for the correct resident for 1 of 5 residents (Resident #2). Findings include: Resident #2 (R2) R2 was admitted on 03/21/24 with primary diagnosis of unspecified dementia with other behavioral disturbances. A physician order dated 06/28/25 for Lorazepam 1 milligram (mg) tablet documented take 1 tablet by mouth every eight hours as needed for anxiety. An Incident report dated 08/10/25 documented R2 was administered .25 milliliters (ml) of lorazepam. After the administration R2 was very sleepy. The facility staff notified the doctor, supervisor and the power of attorney. The Medication Administration Technician called the paramedics. The Paramedics arrived at the facility and assessed R2 and reported R2's vitals' were within normal range, and R2 would be sleepy for a couple of hours.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2758	A. BUILDING _____ B. WING _____	11/10/2025

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
	On 11/10/25 at 1:00PM, the Administrator (ADM) confirmed that R2 was given the wrong dosage of lorazepam. The ADM reported R2 should have been given Lorazepam 1 mg tablet, instead of .25 ml in liquid form of lorazepam to R2. The Administrator reported that the Medication Technician administered the liquid form of Lorazepam which was another residents' medication. Severity: 2 Scope: 1 Complaint #12261			