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 _____	**05/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PACIFICA SENIOR LIVING GREEN VALLEY	**2620 E ROBINDALE ROAD, HENDERSON, NEVADA ,89074**

(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 and Facility Reported Incident completed in your facility on 05/23/24, in accordance with Nevada Administrative Code (NAC) Chapter 449, Requirements for Residential Facilities for Groups. The facility is licensed for 108 Residential Facility for Group beds for elderly and disabled persons with Alzheimer's disease which provide assisted living services, Category II residents. The census at the time of the survey was 95. Twenty resident files and 11 employee files were reviewed. The facility received a grade of D. There was one Facility Reported Incident investigated. Substantiated without deficient Practice: Facility Reported Incident #9927 was substantiated with no deficient practice. The investigation of the Facility Reported Incident included: Observation of residents in the front lobby and throughout the tour of the facility. Interviews were conducted with residents, Medication Technician, Receptionist, and the Business Office Manager. Record Review of twenty one resident records, which included the resident of concern. Document Review included 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: JULIE MASON Title: Executive Director Date: 06/24/2024

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.

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 _____	**05/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PACIFICA SENIOR LIVING GREEN VALLEY	**2620 E ROBINDALE ROAD, HENDERSON, NEVADA ,89074**

(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
0106 SS= E	Personnel File - 1st Aid & CPR - NAC 449.200 Personnel files 2. The personnel file for a caregiver of a residential facility must include, in addition to the information required pursuant to subsection 1: (a) A certificate stating that the caregiver is currently certified to perform first aid and cardiopulmonary resuscitation; Inspector Comments: Based on record review and interview, the facility failed to ensure 4 of 11 employees received in person cardiopulmonary resuscitation (CPR) training, first aid training and/or CPR and first aid training before expiration. (Employee #1, #5, #7 and #11) Findings include: Employee #1 (E1) E1 was hired on 02/08/24 as a Medication Technician. E1's file revealed CPR training was completed online on 03/22/24. E1's record lacked documented evidence of first aid training and the inperson component. Employee #5 (E5) E5 was hired on 07/20/23 as a Medication Technician. E5's file documented CPR and first aid training that expired on 03/31/24 and the in person component Employee #7 (E7) E7 was hired on 06/22/24 as a Caregiver. E7's file revealed CPR training was completed online on 12/04/23. E7's record lacked documented evidence of first aid training and the in person component. Employee #11 (E11) E11 was hired on 02/02/24 as a Caregiver. E11's file revealed CPR training was completed online on 03/09/23. E11's record lacked documented evidence of first aid training and the in person component. On 05/23/24 in the afternoon, the Business Office Manager confirmed the expired CPR and first aid training for E5 and the online CPR with no first aid training for E1, E7 and E11. Severity: 2 Scope: 2	0106	All staff missing CPR certifications will have them completed by July 20th. Going forward, CPR will be schedule monthly for any staff that have expiring certifications or new staff hired without a CPR Certification. This will be a collaborative effort started by our business office manager with support from the management team and oversight by the Executive Director.	07/20/2024
0174 SS= F	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)	0174	Water Temp- The short-term fix is that the MD adjusted the water heaters to bring the water	06/24/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**05/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PACIFICA SENIOR LIVING GREEN VALLEY	**2620 E ROBINDALE ROAD, HENDERSON, NEVADA ,89074**

(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
	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 and interview, the facility failed to ensure water temperatures were within the acceptable range of 100 degrees Fahrenheit (F) to 110 degrees Fahrenheit (F). Findings include: On 05/23/24 between 10:00 AM and 3:25 PM, the water temperature was measured in 28 resident rooms. Seventeen of the 28 resident rooms had a faucet and/or shower water temperature readings exceeding 110 degrees Fahrenheit (F). Room 206: faucet water temperature 131.9 degrees F, shower water temperature 126.0 degrees F. Room 200: faucet water temperature 127.0 degrees F, shower water temperature 125.2 degrees F. Room 301: faucet water temperature 112.8 degrees F, shower water temperature 120.7 degrees F. Room 305: faucet water temperature 122.5 degrees F, shower water temperature 121.3 degrees F. Room 406: faucet water temperature 110.8 degrees F, shower water temperature 120.9 degrees F. Room 400: faucet water temperature 125.2 degrees F, shower water temperature 108.7 degrees F. Room 903: faucet water temperature 132.4 degrees F, shower water temperature 128.1 degrees F. Room 908: faucet water temperature 130.5 degrees F, shower water temperature 127.6 degrees F. Room 608: faucet water temperature 125.6 degrees F, shower water temperature 121.6 degrees F. Room 602: shower water temperature 122.7 degrees F. Room 203: water temperature 119.6 degrees F. Room 301: water temperature 120.7 degrees F. Room 304: water temperature 121.7 degrees F. Blue (Violet) Cottage Room #3A: water temperature 120.0 degrees F. Blue (Violet) Cottage Room #3B: water temperature 124.3 degrees F. White (Daisy) Cottage Room		temperature down. To prevent this from happening in the future, the MD will keep a monthly waterlog whereby she will test the water in each cottage and adjust if necessary.	

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 _____	**05/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PACIFICA SENIOR LIVING GREEN VALLEY	**2620 E ROBINDALE ROAD, HENDERSON, NEVADA ,89074**

(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
	#3A: water temperature 128.0 degrees F. White (Daisy) Cottage Room #2B: water temperature 128.4 degrees F. On 05/23/24 in the morning, the Maintenance Director explained their understanding of the acceptable upper limit for resident room water temperatures was 120 degrees F. The Maintenance Director verbalized not knowing how to correct the problem without the help of the plumber. The Maintenance Director was unable to produce facility water temperature logs because the facility had recently undergone a corporate-driven software program change, and the prior facility records were irretrievable. On 05/23/24 in the afternoon, the Administrator acknowledged the facility faucet and shower water temperatures should have been in the acceptable range of 100 degrees F to 110 degrees F and were not. Severity: 2 Scope: 3			

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 _____	**05/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PACIFICA SENIOR LIVING GREEN VALLEY	**2620 E ROBINDALE ROAD, HENDERSON, NEVADA ,89074**

(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
0178 SS= E	Health & Sanitation - Maintain Int/ext - NAC 449.209 Health and sanitation. (NRS 449.0302) 5. The administrator of a residential facility shall ensure that the premises are clean and that the interior, exterior and landscaping of the facility are well maintained. Inspector Comments: Based on observation and interview, the facility failed to ensure the premises were clean and well maintained. Findings include: The following observations were made on 05/23/24 throughout the day, in and around the facility: Red liquid was on the floor outside Room 202 in the Oak cottage. Many weeds were growing in the courtyard between the Oak and Elm cottages. Paper particles, dust, and other debris were found on the floor of Room 305 in the Elm cottage. A corner of the walls in Room 305 was scraped and without paint. Items identified as being trash by the Maintenance Director were behind the buildings near the fence. Unidentified stains were found on the walls of Room 908 of the White (Daisy) cottage. Room 908 smelled strongly of urine. The carpet was stained from the resident urinating on it, per the Maintenance Director. The carpet was stained in several places throughout the White (Daisy) cottage. The Maintenance Director indicated the facility stopped calling in contractors to clean the carpet for the last two months because the carpet is going to be replaced soon. On 05/23/24, the Maintenance Director acknowledged the areas that needed cleaning and the items that needed to be removed in the interior of the facility and behind the buildings. Severity: 2 Scope: 2	0178	All loose trash has been thrown away which included the trash outside. All carpet has been removed as a part of the remodel. The MD and team will address areas as communicated through hour work order system going forward in addition to our MD making daily rounds.	06/24/2024

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 _____	**05/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PACIFICA SENIOR LIVING GREEN VALLEY	**2620 E ROBINDALE ROAD, HENDERSON, NEVADA ,89074**

(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
0220 SS= E	Laundry & Linen Services Provided - NAC 449.213 Laundry and linen services. (NRS 449.0302) 1. A residential facility shall: (a) Provide laundry and linen services on the premises of the facility; or (b) Contract with a commercial laundry for the provision of those services. 2. A residential facility that provides its own laundry and linen services shall have accommodations which are adequate for the proper and sanitary washing and finishing of linen and other washable goods. 3. The laundry room in a residential facility must be situated in an area which is separate from an area where food is stored, prepared or served. The laundry must be adequate in size for the needs of the facility and maintained in a sanitary manner. The laundry room must contain at least one washer and at least one dryer. All the equipment must be kept in good repair. All dryers must be ventilated to outside the building. If a washer or dryer is located outside the residential facility, the washer or dryer must be in a room or enclosure. Inspector Comments: Based on observation and interview, the facility failed to ensure the laundry rooms were kept in a sanitary manner. On 05/23/24 in the morning and in the afternoon, the following were observed n the facility's laundry rooms: Elm cottage: Dust clumps were found behind and around the washer and dryer. Maple cottage: Lint was found in the lint trap of the dryer. Red (Rose) cottage: Trash was on the floor of the laundry room. Yellow (Sunflower) cottage: Lint was built up in the lint trap, plastic bags and lint were located behind the dryer. Blue (Violet) cottage: Lint was on the floor around the dryer. The Maintenance Director acknowledged the lint build-up in the lint traps, and the trash and other items in the laundry rooms, and indicated the lint traps and laundry rooms should have been kept clean. Severity: 2 Scope: 3	0220	Laundry Rooms- The light debris found in the laundry room was thrown away during the visit and trash cans are being purchased for each laundry room. In addition, each laundry room will have a lint trap check off for the staff to document when checking/emptying during their daily routine. MD will check this log monthly.	06/24/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PACIFICA SENIOR LIVING GREEN VALLEY	2620 E ROBINDALE ROAD, HENDERSON, NEVADA ,89074

(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
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 05/23/2024, 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 heavy dust build-up on the back coils of the evaporator fan in the walk-in cooler. b. The seams between the floor panels in both the walk-in cooler and walk-in freezer were soiled with food debris. Severity: 2 Scope: 1	0255	Both the coil and the evaporator fan have been cleaned to remove the dust builds up. The floors have also been cleaned of mentioned debris. Also, both items have been added to the kitchen weekly check off cleaning sheet.	06/24/2024
0878 SS= D	Medication/OTCS, Supplements, Change Order - NAC 449.2742 and R043-22 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 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	0878	The community will conduct a medication self-audit to clear up and fix all missing PO's, medication storage issues, and expired medications. This will be conducted by our RSD and RSC between 6/24-6/28. Going forward, this will be conducted monthly to ensure better compliance with our medication program.	06/28/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**05/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PACIFICA SENIOR LIVING GREEN VALLEY	**2620 E ROBINDALE ROAD, HENDERSON, NEVADA ,89074**

(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
	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 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 observation, record review and interview, the facility failed to ensure there were physician orders for 2 of 20 residents. (Resident #4 and #5) Resident #4 (R4) R4 was admitted on 11/21/23, with diagnoses including hypothyroidism and diabetes. On 05/23/24 at 11:30 AM, observed a bottle of Systane Sterile Lubricating eye drops on top of the mini refrigerator in R4's room The eye drops expired 03/2022. R4 indicated they used the eye drops every once in awhile. On 05/23/24 in the morning, the eye drops were not listed on the May 2024 Medication Administration Record (MAR). On 05/23/24 at 12:50 PM, a Medication			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**05/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PACIFICA SENIOR LIVING GREEN VALLEY	**2620 E ROBINDALE ROAD, HENDERSON, NEVADA ,89074**

(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
	Technician confirmed the medication observed in R4's room did not have a physician order. Resident #5 (R5) R5 was admitted on 09/28/20, with diagnoses including severe alcohol use disorder and a right arm injury. On 05/23/24 at 11:40 AM, observed the following medications on a table next to R5's recliner in their room: -Tadalix Advanced High Boost 1050 milligrams (mg) -Seman Flow Max Capsules dietary supplement -Krill Oil 1000 mg Omega 3 -Semanoid dietary supplement (two bottles) -Five tubes of 1% Clotrimazole Antifungal Cream (one open tube) R5 indicated they did not need a prescription for these medications and used them when they wanted to. On 05/23/24 at 12:50 PM, a Medication Technician confirmed the medications observed in R5's room did not have a physician order. Severity: 2 Scope: 1			
0920 SS= F	Medication: Storage - NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. (NRS 449.0302) 1. Medication, including, without limitation, any over-the-counter medication, stored at a residential facility must be stored in a locked area that is cool and dry. The caregivers employed by the facility shall ensure that any medication or medical or diagnostic equipment that may be misused or appropriated by a resident or any other unauthorized person is protected. Medications for external use only must be kept in a locked area separate from other medications. A resident who is capable of administering medication to himself or herself without supervision may keep the resident ' s medication in his or her room if the medication is kept in a locked container for which the facility has been provided a key. 2. Medication stored in a refrigerator, including, without limitation, any over-the-counter medication, must be kept in a locked box unless the refrigerator is locked or is located in a locked room. Inspector Comments: Based on	0920	The community is having hospice and families provide shower caddies and locked cabinets for their items. Those who do their own medications will have a lock box by 7/31 for their medications. The community will conduct a medication self-audit to clear up and fix all missing PO's, medication storage issues, and expired medications. This will be conducted by our RSD and RSC between 6/24-6/28. Going forward, this will be conducted monthly to ensure better compliance with our medication program.	06/28/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**05/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PACIFICA SENIOR LIVING GREEN VALLEY	**2620 E ROBINDALE ROAD, HENDERSON, NEVADA ,89074**

(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
	observation, document review, record review and interview, the facility failed to ensure medications were secured. Findings include: Resident #4 (R4) On 05/23/24 at 11:30 AM, observed a bottle of Ammonium 12% Lactic Acid Lotion in the shower in R4's bathroom. There was a bottle of Systane Sterile Lubricating eye drops on top of the mini refrigerator in R4's room The eye drops expired 03/2022. R4 indicated they used the eye drops every once in awhile. R4's Ultimate User Agreement dated 11/15/23, indicated the facility would manage all medications. On 05/23/24 at 12:50 PM, a Medication Technician confirmed the medications observed did not belong in R4's room. Resident #5 (R5) On 05/23/24 at 11:40 AM, observed the following medications on a table next to R5's recliner in their room: -Tadalix Advanced High Boost 1050 milligrams (mg) -Seman Flow Max Capsules dietary supplement -Krill Oil 1000 mg Omega 3 -Semanoid dietary supplement (two bottles) -Five tubes of 1% Clotrimazole Antifungal Cream (one open tube) R5 indicated they did not need a prescription for these medications and used them when they wanted to. R5's Ultimate User Agreement dated 09/23/20, indicated the facility would manage all medications. On 05/23/24 at 12:50 PM, a Medication Technician confirmed the medications observed did not belong in R5's room. The facility's Medication Storage - Centrally Stored Medications, policy MP12 (dated 12/01/23), documented all medications, including over-the-counter medications were kept in locked storage at all times... The caregivers shall ensure any medication that may be misused or appropriated by a resident was protected... On 05/23/24 on a facility tour in the morning, Room 406 of the Maple memory care cottage was found to contain the following medications in and around an unsecured medication bin on the table, and other areas of the apartment, for Resident #21 (R21). Ketoconazole Shampoo 2% Triamcinolone Acetonide		The community will conduct a medication self-audit to clear up and fix all missing PO's, medication storage issues, and expired medications. This will be conducted by our RSD and RSC between6/24-6/28. Going forward, this will be conducted monthly to ensure better compliance with our medication program. The community will conduct a medication self-audit to clear up and fix all missing PO's, medication storage issues, and expired medications. This will be conducted by our RSD and RSC between 6/24-6/28. Going forward, this will be conducted monthly to ensure better compliance without medication program.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**05/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PACIFICA SENIOR LIVING GREEN VALLEY	**2620 E ROBINDALE ROAD, HENDERSON, NEVADA ,89074**

(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
	(expired 10/02/18) Mupirocin ointment 2% (expired 11/09/22) Suppositories for hemorrhoids Phenol 1.4% sore throat spray Antacid tablets Vaporizing chest rub Fluticasone Dry eye therapy Four bottles of nasal spray Resident #21's lockable medication chest was unlocked and within resident reach on a table in Room 406. In interview on 05/23/24 at 11:25 AM, R21 explained they could self-administer their own medications however they resided with their spouse (Resident #22) who did not self-administer their own medications. On 05/23/24 in the morning, the following unsecured medications were found in Room 403 of the Maple memory care cottage: Two bottels of antacid tablets Laxative powder Zinc oxide 20.0% ointment Glycerin suppositories The following items were found unsecured in the Oak memory care cottage: An unsecured storeroom off of the Kitchen contained Calmoseptine Ointment, Calazine Zinc Oxide Paste, and Dermal Wound Cleanser. The following items were found unsecured in the Elm memory care cottage: Unlocked Room 305 had Phytoplex Skin cream and Phytoplex Silicone Cream. The following items were found unsecured in the Maple memory care cottage: Unlocked Room 400 contained Pain Relief Cream and Skin Protectant Cream. Unlocked Room 403 contained Healing Ointment, Calazine Ointment, Zinc Oxide 20%, and Glycerin Suppositories. On 05/23/24, the Maintenance Director acknowledged unsecured medications were in resident rooms and should not be there. Severity: 2 Scope: 3			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**05/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PACIFICA SENIOR LIVING GREEN VALLEY	**2620 E ROBINDALE ROAD, HENDERSON, NEVADA ,89074**

(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
0991 SS= D	Alzheimer 's Care Standards for Safety - NAC 449.2756 and R043-22 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 or other forms of dementia who meet the criteria prescribed in paragraph (a) of subsection 2 of NRS 449.1845 shall ensure that: (b) Operational alarms, buzzers, horns or other technology for notifying staff when a door is opened are installed on all doors that may be used to exit the facility. Inspector Comments: Based on observation and interview, the facility failed to ensure a door alarm in a memory care cottage was engaged. Findings include: On 05/23/24 at 10:16 AM, one of the exit doors of the Oak memory care cottage was opened and the alarm did not sound. The Maintenance Director manually enabled the alarm and demonstrated it was operative. On 05/23/24, the Maintenance Director acknowledged the alarm did not sound when the door was opened, and indicated it must have been disabled by staff. Severity: 2 Scope: 3	0991	MC Alarm Sound- The short-term fix is that the Maint Director latched the door for correct function. The long term is that the ED/MD will perform a monthly Audit whereby he/she checks that the alarms/gates are working properly Both Scissor and empty Reynolds wrap box have been removed or secured. RSD or RSC will inspect going forward to ensure that sharp items are not accessible to our residents in MC	06/24/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**05/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PACIFICA SENIOR LIVING GREEN VALLEY	**2620 E ROBINDALE ROAD, HENDERSON, NEVADA ,89074**

(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
0994 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 and R043-22 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 or other forms of dementia who meet the criteria prescribed in paragraph (a) of subsection 2 of NRS 449.1845 shall ensure that: (e) Knives, matches, firearms, tools and other items that could constitute a danger to the residents of the facility are inaccessible to the residents. Inspector Comments: Based on observation and interview, the facility failed to ensure sharp objects were secure in the memory care areas. Findings include: On 05/23/24 at 09:28 AM on a tour of the Oak memory care cottage, the serrated cutting edge of a plastic wrap dispenser was found loose in the dispenser box in an unlocked cupboard in the unsecured kitchen. On 05/23/24 at 10:20 AM on a tour of the Elm memory care cottage, the serrated cutting edge of a plastic wrap dispenser was found loose in the dispenser box in an unlocked cupboard in the unsecured kitchen. On 05/23/24 at 10:42 AM on a tour of the Maple memory care cottage, a pair of scissors were found in the unlocked cutlery drawer in the unsecured kitchen. On 5/23/24 in the morning, the Maintenance Director acknowledged the unsecured sharp objects in the memory care areas. Severity: 2 Scope: 3	0994	Both Scissor and empty Reynolds wrap box have been removed or secured. RSD or RSC will inspect going forward to ensure that sharp items are not accessible to our residents in MC	06/24/2024
0999 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 and R043-22 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 or other forms of dementia who meet the criteria	0999	An in-service will be conducted during the week of 6/24 regarding toxic substances. In addition, MD, RSD, and RSC will continue to monitor during daily and weekly rounds for resident safety.	06/28/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**05/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PACIFICA SENIOR LIVING GREEN VALLEY	**2620 E ROBINDALE ROAD, HENDERSON, NEVADA ,89074**

(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
	prescribed in paragraph (a) of subsection 2 of NRS 449.1845 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 not accessible to residents. Findings include: On a tour of the facility on 05/23/24 in the morning, toxic substances were unsecured in three resident cottages. The following items were found unsecured in the Oak memory care cottage: The kitchen had Glass Cleaner, Neutral Disinfectant, Disinfectant/Deodorizer, Hand Soap labeled "Keep Out of Reach of Children." An unsecured storeroom off of Kitchen contained Skin Therapy Lotion, Shaving Cream, Moisture Barrier Ointment, Body Cleanser, Perineal Cleaner, Hydrogel Wound Care, and Mouthwash. Unlocked Resident Room 206 had unsecured Shampoo and Body Wash. Unlocked Room 200 contained Makeup, Deoderant, Hand soap, Body lotion, Shampoo, and Body Wash. The following items were found unsecured in the Elm memory care cottage: The unlocked Laundry Room had High Efficiency Detergent. Unlocked Room 301 had Deoderant, Analgesic Lotion, Toothpaste, and Nail polish. The following items were found unsecured in the Maple memory care cottage: The unlocked laundry room had Glass Cleaner, Bathroom cleaner with bleach, and Disinfectant. Unlocked Room 400 had Fragrance Mist, labeled "Flammable," Shower gel, Body wash, Body lotion, Shaving cream, Dry mouth oral rinse, Hair spray, and Deoderant. Unlocked Room 403 had Shampoo, Conditioner, Disinfecting wipes, Aerosol air freshener, Face cleanser, Mouthwash, and Glass cleaner. Unlocked Room 406 had Shampoo, Lotion, and Conditioning Mousse. On 05/23/24 in the morning, the Maintenance Director acknowledged the presence of unsecure toxic substances in			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**05/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PACIFICA SENIOR LIVING GREEN VALLEY	**2620 E ROBINDALE ROAD, HENDERSON, NEVADA ,89074**

(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
	the Oak, Elm, and Maple memory care cottages. The Maintenance Director said they were not aware of the requirement. On 05/23/24 in the afternoon, toxic substances were present in two transitional care cottages. The following items were found unsecured in the White (Daisy) cottage: Unlocked Room 900 had Perfume, Lotion, Facial soap, Hair Mousse, and Hand soap. Unlocked Room 903 had Shower gel, Shampoo, Air freshener, Petroleum jelly, Face cream, and Nail polish. Unlocked Room 908 had Hand soap and Body wash. The following items were found unsecured in the Red (Rose) cottage: Body wash and Zinc oxide paste. On 05/23/24 in the afternoon, the Maintenance Director acknowledged the unsecured toxic substances in theWhite (Daisy) and Red (Rose) transitional care cottages. Severity: 2 Scope: 3			
1540 SS= F	Cultural Competency Training - Cultural Competency Training R016-20 Sec. 14 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. R016-20 Sec. 14 2. The facility shall provide the training required by subsection 1 through a course or program that is approved by the Director of the Department or his or her designee pursuant	1540	All necessary staff are signed up for the next class which is on 6/28. Going forward we will make sure all new staff attend the monthly class that is provided by the state. This will be facilitated by our Business Office Manager with oversight from our Executive Director.	06/28/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**05/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PACIFICA SENIOR LIVING GREEN VALLEY	**2620 E ROBINDALE ROAD, HENDERSON, NEVADA ,89074**

(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
	to section 17 of this regulation and is assigned a course number by the Division pursuant to section 18 of this regulation. R016-20 Sec. 14 3. The facility shall keep documentation in the personnel file of any agent or employee of the facility of the completion of the cultural competency training required pursuant to subsection 1. R016-20 Sec. 15 1. Within 90 days after a facility is licensed to operate, the facility must submit to the Department on a form prescribed by the Department the course or program which the facility will use to provide cultural competency training. The facility may: (a) Develop or operate the course or program; or (b) Contract with a third party to develop and operate the course or program. R016-20 Sec. 15 2. The course or program submitted by the facility pursuant to subsection 1 must address patients or residents who have different cultural backgrounds from that of the agent or employee of the facility, 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. R016-20 Sec. 15 3. When a facility submits a course or program pursuant to subsection 1, the facility must also provide to the Department the following information for the instructor of the course or program: (a) The application of the instructor who will teach the course or program; (b) Three letters of recommendation for the instructor, including, without limitation, at least one letter of recommendation in which the recommender has knowledge of the methods the instructor uses in teaching a cultural competency course or program; and (c) The resume of the instructor of the course or program that includes, without limitation, the education, training and experience the instructor has in providing cultural competency training. R016-20 Sec. 15 4. Except as otherwise provided in subsection 5, when a facility submits a course or program pursuant to subsection 1,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**05/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PACIFICA SENIOR LIVING GREEN VALLEY	**2620 E ROBINDALE ROAD, HENDERSON, NEVADA ,89074**

(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
	the facility must also provide to the Department: (a) The syllabus of the course or program; (b) The following information: (1) The name of the facility; (2) The address of the facility; (3) The electronic mail address of the facility; (4) The license number of the facility; and (5) The name and contact information of a person who represents the facility and who can discuss the course or program submitted by the facility pursuant to subsection 1; (c) If the facility contracts with a third party who develops and operates the course or program, the following information: (1) The name of the third party; (2) The address of the third party; (3) The electronic mail address of the third party; and (4) The name and contact information of a person who represents the third party and who can discuss the course or program submitted by the facility pursuant to subsection 1; (d) Evidence that the subjects covered by the course or program include, without limitation, the course materials required by section 16 of this regulation; (e) A sample sign-in sheet for the course or program that contains: (1) The dates of the course or program; and (2) A place for a participant of the course or program to print and sign his or her name; (f) A sample evaluation form that a participant of the course or program may complete at the end of the course or program which evaluates: (1) The content of the course or program; (2) The instructor of the course or program; and (3) The manner in which the course or program is presented to the participant; and (g) A sample document that a participant of the course or program may complete at the end of the course or program in which the participant can perform a self-evaluation. R016-20 Sec. 15 5. A facility may submit a course or program pursuant to subsection 1 without submitting the information required in subsection 4 if the course or program: (a) Is provided by: (1) A nationally recognized organization, as determined by the Director of the Department; (2) A federal, state or			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**05/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PACIFICA SENIOR LIVING GREEN VALLEY	**2620 E ROBINDALE ROAD, HENDERSON, NEVADA ,89074**

(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
	local government agency; or (3) A university or college that is accredited in the District of Columbia or any state or territory of the United States; and (b) Provides proof of completion upon the participant of the course or program completing the course or program that the Director or his or her designee determines to be satisfactory. R016-20 Sec. 15 6. When a facility submits pursuant to subsection 1 a course or program that is described in subsection 5, the facility must also provide to the Department: (a) The name of the course or program; (b) The name of the organization, agency, university or college providing the course or program; (c) If the course or program is provided online, the URL of the course or program; (d) If the course or program is provided through a training system, access to the training system; (e) If the course or program is not provided online or through a training system, the syllabus of the course or program; (f) The following information: (1) The name of the facility; (2) The address of the facility; (3) The electronic mail address of the facility; (4) The license number of the facility; and (5) The name and contact information of a person who represents the facility and who can discuss the course or program submitted by the facility pursuant to subsection 1; and (g) Any other information the Department requests to assist the Director or his or her designee in determining whether or not to approve the course or program pursuant to section 17 of this regulation. 7. As used in this section, "URL" means the Uniform Resource Locator associated with an Internet website. R016-20 Sec. 16 1. A course or program subject to the requirements of subsection 4 of section 15 of this regulation must include, without limitation, the following course materials: (a) An overview of cultural competency; (b) An overview of implicit bias and indirect discrimination; (c) The common assumptions and myths concerning stereotypes and examples of such			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**05/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PACIFICA SENIOR LIVING GREEN VALLEY	**2620 E ROBINDALE ROAD, HENDERSON, NEVADA ,89074**

(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
	assumptions and myths; (d) An overview of social determinants of health; (e) An overview of best practices when interacting with persons who fall within one or more of the categories in paragraphs (a) to (f), inclusive, of subsection 1 of NRS 449.103; (f) An overview of gender, race and ethnicity; (g) An overview of religion; (h) An overview of sexual orientation and gender identities or expressions; (i) An overview of mental and physical disabilities; (j) Examples of barriers to providing care; (k) Examples of language and behaviors that are discriminatory; and (l) Examples of a welcoming and safe environment. R016-20 Sec. 16 2. The course materials included in a course or program, including, without limitation, the course materials required by subsection 1, must include, without limitation: (a) Evidence-based, peer-reviewed sources; (b) Source materials that are used in universities or colleges that are accredited in the District of Columbia or any state or territory of the United States; (c) Source materials that are from nationally recognized organizations, as determined by the Director of the Department; (d) Source materials that are published or used by federal, state or local government agencies; or (e) Other source materials that are deemed appropriate by the Department. R016-20 Sec. 17 4. The facility shall submit the additional information that the facility needs to submit pursuant to paragraph (b) of subsection 3 within 45 days after being notified that the course or program is not approved pursuant to paragraph (a) of subsection 3. Upon receiving the additional information, the Director or his or her designee may approve the course or program. If the additional information is not received or fails to include all of the information that the Director or his or her designee informed the facility that it needed to submit, the Director or his or her designee shall not approve the course or program.			

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 _____	**05/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PACIFICA SENIOR LIVING GREEN VALLEY	**2620 E ROBINDALE ROAD, HENDERSON, NEVADA ,89074**

(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
	Inspector Comments: Based on record review and interview, the facility failed to ensure 6 of 11 employees were in compliance with Nevada Revised Statutes (NRS) 449.103, regarding initial cultural competency training. (Employee #1, #2, #3, #4, #5 and #8) Findings include: Employee #1 (E1) E1 had a start date of 02/08/24 as a Medication Technician. E1's record lacked documented evidence of cultural competency training. Employee #2 (E2) E2 had a start date of 01/18/24 as a Caregiver. E2's record lacked documented evidence of cultural competency training. Employee #3 (E3) E3 had a start date of 02/08/24 as a Concierge. E3's record lacked documented evidence of cultural competency training. Employee #4 (E4) E4 had a start date of 05/06/24 as a Caregiver. E4's record lacked documented evidence of cultural competency training. Employee #5 (E5) E5 had a start date of 07/20/23 as a Medication Technician. E5's cultural competency training was dated 03/29/24, beyond the 30 days from hire date. Employee #8 (E8) E8 had a start date of 10/26/23 as a Medication Technician. E8's record lacked documented evidence of cultural competency training. On 05/23/24 in the afternoon, the Business Office Manager confirmed the cultural competency training was not completed within 30 days of hire for E5 and there was no documented cultural competency training for E1, E2, E3, E4 and E8. Severity: 2 Scope: 3			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	**05/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PACIFICA SENIOR LIVING GREEN VALLEY	**2620 E ROBINDALE ROAD, HENDERSON, NEVADA ,89074**

(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
1830 SS= D	Infection Control Required Training - Infection Control Required Training LCB File No. R048-22 Sec. 5 4. The persons designated pursuant to subsection 3 as responsible for infection control shall complete not less than 15 hours of training concerning the control and prevention of infections provided by the Association for Professionals in Infection Control and Epidemiology, Inc., the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the World Health Organization or the Society for Healthcare Epidemiology of America, or a successor in interest to any of those organizations, not later than 3 months after being designated and annually thereafter. 5. Training completed pursuant to subsection 4 may be in any format, including, without limitation, an online course provided for compensation or free of charge. A certificate of completion for the training must be maintained in the personnel file of each person designated pursuant to subsection 3 for 3 years immediately following the completion of the training. Inspector Comments: Based on record review and interview, the facility failed to ensure the primary infection control designee acquired the required initial 15 hour infection control training. (Employee #9) Findings include: On 05/23/24 in the afternoon, the record for Employee #9 (E9), the primary infection control designee, lacked documented evidence of the initial 15 hours of training concerning the control and prevention of infections from the approved nationally recognized organizations. On 05/23/24 in the afternoon, the Business Office Manager confirmed the required infection control and prevention training from a nationally recognized organization had not been completed for E9. Severity: 2 Scope: 1	1830	All staff that are missing the infection control certificate are working to have completed by 6/30. Going forward, infection control will be included with new staff onboarding which is conducted by our Business Office Manager	06/30/2024

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 _____	**05/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PACIFICA SENIOR LIVING GREEN VALLEY	**2620 E ROBINDALE ROAD, HENDERSON, NEVADA ,89074**

(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
1840 SS= D	UNL Caregiver Training - R063-21 Sec. 4 1. An unlicensed caregiver who provides care to residents, patients or clients at a facility described in section 3 of this regulation shall annually complete evidence-based training provided by a nationally recognized organization concerning the control of infectious diseases. The training must include, without limitation, instruction concerning: (a) Hand hygiene; (b) The use of personal protective equipment, including, without limitation, masks, respirators, eye protection, gowns and gloves; (c) Environmental cleaning and disinfection; (d) The goals of infection control; (e) A review of how pathogens, including, without limitation, viruses, spread; and (f) The use of source control to prevent pathogens from spreading. 2. Each unlicensed caregiver who completes the training required by subsection 1 must provide proof of completion of that training to the administrator or other person in charge of the facility in which the unlicensed caregiver provides care. Inspector Comments: Based on record review and interview, the facility failed to ensure 2 of 11 employees received infection control training through a nationally recognized course. (Employee #6 and #7) Findings include: Employee #6 (E6) E6 had a start date of 03/03/16 as the Resident Services Coordinator. E6's record lacked documented evidence of Infection Control training. Employee #7 (E7) E7 had a start date of 06/07/22 as a Caregiver. E7's record lacked documented evidence of Infection Control training. On 05/23/24 at 12:50 PM, the Business Office Manager confirmed there was no documented infection control training for E6 and E7. Severity: 2 Scope: 1	1840	All staff that are missing the infection control certificate are working to have completed by 6/30. Going forward, infection control will be included with new staff onboarding which is conducted by our Business Office Manager	06/30/2024