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 _____	**10/13/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PACIFICA SENIOR LIVING SAN MARTIN	**8374 W CAPOVILLA AVE, LAS VEGAS, NEVADA ,89113**

(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 initiated at your facility on 09/12/22 and completed on 10/13/22, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 150 Residential Facility for Group beds which provides assisted living services for elderly and disabled persons and/or persons with Alzheimer's disease and/or persons with chronic illness, Category II residents. The sample size was five. The facility received a grade of A. One complaint was investigated. Complaint #NV00066893 with seven allegations was unsubstantiated. Allegation #1: A resident was bullying the Resident of Concern could not be substantiated based on review of incident reports from June 2022 - August 2022 which did not include incidents of bullying. Interviews with two caregivers, the Business Office Manager, and the Regional Director of Operations who explained the alleged perpetrator did not have documented behaviors of bullying. Interviews with five residents who explained they had not experienced bullying from any other residents including the alleged perpetrator. Allegation #2: The facility failed to conduct hourly checks on the Resident of Concern could not be substantiated based on a review of a Resident Assessment dated 03/31/22 which documented the resident would have checks four times per shift. A review of a grievance report dated 08/04/22 documented the family wanted additional checks on the resident. Reviewed hourly checklists for August 2022 which documented hourly checks were completed after the grievance report was filed until the resident passed away in mid-August 2022. The Resident Services Coordinator confirmed after the grievance was received the facility updated the Resident's Needs Assessment to include additional hourly	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.

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	checks. Allegation #3: The facility failed to report three falls, including a fall on the facility's bus could not be substantiated based on a review of all incident reports with falls from January 2022 to August 2022 which included one fall in August 2022 in the presence of the resident of concern's hospice agency representative and was documented. Interviews with the Bus Driver who explained they were the only bus driver employed by the facility and there were no incidents where the Resident of Concern experienced a fall on the bus. The Bus Driver reported, if the Resident of Concern had experienced a fall on the bus an incident report would have been created and submitted to management. Allegation #4: Residents were entering into other resident's rooms without permission could not be substantiated based on interviews with five residents who denied other residents, or staff had entered their room without permission. Interview with the Business Office Manager and two caregivers who denied receiving complaints of other residents entering other resident's rooms without permission. A review of incident reports from January 2022 to August 2022 did not document complaints from residents about unauthorized entrance to other resident's rooms. Allegation #5: It took staff an hour and a half to respond to a call bell on 08/01/22 could not be substantiated based on review of the facility call log which documented the Resident of Concern's pendant was pressed at 12:05 PM and 04:14 PM and the response time recorded was less than 10 minutes for each instance. Interviews with five residents who denied they had waited longer than 30 minutes after they pushed their call pendant for a caregiver to respond. Review of the facility policy for pendant checks revealed the facility checked each pendant to ensure they were functioning as intended on a monthly basis. Allegation #6: The fire exit door on the Southwest side of the building was stuck could not be substantiated based			

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	on the exit doors were magnetic release doors. All exit doors were released after pushing the push bar once and again after the first push to disengage the magnetic lock. Interview with the Business Office Manager who confirmed the doors were magnetic release doors and were locked on the outside to prevent unauthorized entry. The Business Office Manager confirmed the magnetic lock could be disengaged on the inside of the door by pushing on the push bar once and immediately after to disengage the lock. The Business Office Manager explained if a fire was detected, or the power went out, the fire system sent a signal to all the doors to release the magnetic locks. Allegation #7: A resident's property was reported as stolen could not be substantiated. The facility failed to follow policies and procedures related to theft of resident's property was investigated previously on 08/18/22 and was substantiated with a deficiency. The investigation into the allegations included: Observations of resident and employee interactions in four resident rooms, the dining room, and in the hallways and resident's personal belongings in their rooms. Observations of how the exit doors did open when pushed as designed. Caregivers responded to call pendants when pressed and pull cords when pulled. Interviews with five residents, two caregivers, the Bus Driver, The Business Office Manager, The Resident Services Coordinator, and the Regional Director of Operations. Documentation review of the facilities' call bell response policy, resident Care Needs Assessment for five residents. All incident reports for January 2022 - August 2022. Grievances received from June 2022 - August 2022. Hourly checks log for the Resident of Concern for August 2022, and the Call bell Response Log for August 2022. 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			

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	investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. There were no regulatory deficiencies identified. No further action necessary. Please retain a copy for your records.			