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 _____	**08/17/2023**

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 State Licensure complaint investigation conducted in your facility on 08/17/23, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The census at the time of the survey was 95. The sample size was five. There were two complaints investigated. The facility received a grade of A. Unverified: 1. Complaint #NV00069199 could not be verified. No regulatory deficiencies could be identified. 2. Complaint #NV00069004 could not be verified. No regulatory deficiencies could be identified. The investigation of the complaint included: Observation of residents who were well groomed and did not smell of urine and a resident's apartment door and surrounding areas. Interviews were conducted with residents, Caregivers, hospice Certified Nurse Assistant, a physician, Maintenance Director and the Maintenance Assistant, Resident Services Director, and Administrator. Record Review of resident records, which included the resident of concern. Document Review of facility policies and procedures, maintenance requests, supply orders, and Resident Service Director's personal notes. 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		
0670 SS= D	Discharge of Resident; Notice of Discharge - NAC 449.2708 Discharge of resident; notice of discharge; issuance of notice to quit to resident for improper or harmful behavior. (NRS 449.0302) 1. A resident may be discharged from a residential facility without his or her approval if: (a) The	0670	1. Going forward, ED and RSD will assign appropriate level of care to residents, have care team meetings as needed especially when/if changes of condition are reported. 2. Routine assessments of residents will be done to make sure they are at the correct level of care for their needs.	09/08/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: TORREY DONNER Title: Executive Director Date: 09/08/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	resident fails to pay his or her bill within 5 days after it is due; (b) The resident fails to comply with the rules or policies of the facility; or (c) The administrator of the facility or the Bureau determines that the facility is unable to provide the necessary care for the resident. Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 5 sampled residents were discharged after a significant change of condition (Resident #1). Findings include: Resident #1 (R1) R1 was admitted on 08/20/22, with a diagnosis of mild cognitive impairment. A physician's report dated 08/16/22, documented R1 was alert and oriented to person, place, and time. The physician's report documented R1 was able to care for activities of daily living independently. The Resident Level of Care dated 08/23/22, documented resident was independent of all needs and received no care from facility staff. On 12/21/22, R1 was sent to the hospital due to a significant change in condition. R1 was in the common area and had aggressive behavior towards staff when staff tried to assist R1 after having a bowel movement that leaked down R1's legs. R1 was also noted to have swollen legs. 12/21/22 hospital report documented R1 was oriented to self and had no signs of infection. R1 was re admitted from the hospital to the facility. 02/10/23 narrative charting on R1 documented R1 had an uncontrolled bowel movement and when staff tried to assist them, R1 became combative and aggressive towards staff. 02/15/23 narrative charting on R1 documented R1 was aggressive and walking around naked in the community. 04/28/23 narrative charting on R1 documented R1 was walking around arguing with other residents in the dining room and R1 yelled at the front desk personnel. R1 had on a dirty sweatshirt and was not wearing pants and was combative towards Administrator when re-directed. A		3. Will implement a binder of assessments to be monitored and updated on a 30, 60, 90 day cycle or as needed. 4. ED and RSD. 5. 9/11/2023 6. See attached. 7. ED and RSD will monitor upcoming assessments to make sure they are done on time, and accurately.	

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	Medication Technician was able to calm R1 down, however R1 was unable to answer questions and was talking about things from R1's past. R1 was admitted to the hospital on 06/19/2023 for passing out. 06/20/23 hospital notes documented R1 had syncope and had a diagnosis of dementia. 06/21/23 narrative charting on R1 documented Resident Services Director spoke to R1's family and indicated a change of level of care was needed and should be transferred to memory care. There was no documented evidence the facility tried to change R1's level of care or discharge R1 prior to 06/21/23. On 08/17/23, two Medication Technicians and the Resident Services Director reported R1 was combative towards staff and refused help. R1 was independent with care; however, was not taking care of themselves, smelled of urine, and refused medication. R1 had several episodes of yelling and being disruptive to other residents in the dining room. On 08/17/23, the Resident Services Director reported R1's family was notified about R1's behavior and needed a higher level of care; however, the family refused indicating they could not afford to pay the higher costs. The Resident Services Director indicated once when R1 had a bowel movement running down their legs R1 was unaware it had occurred. On 08/17/23, the Administrator reported R1 was violent to staff, refused assistance, was not taking care of themselves, and had tried to attack other residents with their walker. The Administrator reported the facility had informed the family about R1's behavior and the family did not believe the facility about R1's behaviors and refused to pay for a higher level of care due to R1 not being able to afford it. The Administrator reported R1 was not an elopement risk, so the facility tried to keep R1 instead of transferring them to a higher level of care. The Administrator reported a notice to vacate was not provided to R1 and there was no evidence the facility tried to increase the level of care			

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	or transfer R1 to memory care prior to 06/21/23. Severity: 2 Scope: 1			