

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 2678	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER ATRIA SEVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 2000 N RAMPART BLVD, LAS VEGAS, NEVADA ,89128		
(X4) ID PREFIX TAG RFG 0000- No Deficiencies	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. The RFG was found to be in substantial compliance. No regulatory deficiencies were identified. No further action is necessary. Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation survey, completed at your facility on 03/19/26, in accordance with Nevada Administrative Code (NAC) Chapter 449, Requirements for Residential Facilities for Groups. The facility is licensed for 144 Residential Facility for Group beds for elderly and disabled persons and/or Assisted Living Services and/or persons with mental illness, 103 Category I residents and 41 Category II residents. The census at the time of the survey was 120. The sample size was five residents.	ID PREFIX TAG RFG 0000- No Deficiencies	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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

Title:

Date:

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	The facility received a grade of A. There were two complaints investigated. Substantiated without deficient Practice: 1. Complaint #13200 was substantiated with no deficient practice. No regulatory deficiencies could be identified. 2. Complaint #13297 was substantiated with no deficient practice. No regulatory deficiencies could be identified. The investigation of Complaints included: Observation of infection control supplies and practices, no residents in isolation, and dining room and commercial kitchen walls and ceiling. Interviews were conducted with residents, caregivers, dietary services employees, the regional dietary manager, a Resident Services Director and the Administrator. Clinical Record Review of five records. Document Review included facility policy and procedures, remediation and moisture reports, employee injury log, service reports and OSHA corrective action reports and incident reports.			