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 _____	**01/23/2025**

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
0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of a Facility Reported Incident investigation completed in your facility on 01/23/25, in accordance with Nevada Administrative Code, Chapter 449, Requirements for Residential Facilities for Groups. The census at the time of the survey was 53. The facility received a grade of A. The sample size was five. There was one Facility Reported Incident (FRI) investigated. The FRI was substantiated with deficient practice. (See TAG 815) 1. FRI #10837 The investigation of the FRI included: -Tour of the facility and observations of audible alarms on each exit door. -Interviews were conducted with the Residents, Administrator and Medication Technician. -Clinical record review of five residents, including the Resident of Concern. -Document review of Incident Reports and the facility elopement policy. 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 investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiency was identified:	0000		
0815 SS= G	Residents Requiring Protective Supervision - NAC 449.2732 and R043-22 Residents requiring protective supervision. (NRS 449.0302) 3. The administrator of a residential facility with a resident who requires protective services shall ensure that: (a) The caregivers employed by the facility are capable of providing the supervision for that resident without neglecting the needs of the other residents of the facility; and (b) The person-centered service plan developed for that resident provides for protective supervision for that resident.	0815	1) Resident1 was discharged from the community on 1/1/2025. 2) Residents were audited to determine high risk elopement risk and the Personal Care plans were reviewed. 3) Newly admitted residents will be reviewed for for high risk elopement and if identified as high risk their person centered care plan will be updated to ensure protective supervision is in place. 4) Residents that have been identified as a high elopement risk will have their person centered care plan audited by RSD, Cindy Aragon-Harris weekly x4 and monthly x2 to ensure protective supervision is in place. 5)	12/23/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: STACEY SHEATS Title: Acting Executive Director Date: 03/03/2025

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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	Inspector Comments: Based on observation, document review, record review and interview the facility failed to ensure a person-centered care plan was updated to ensure protective supervision due to high elopement risk was in place at admit and after a resident eloped from the facility for 1 of 5 residents (Resident #1). Findings include: On 1/23/25 the facility was located across the street from a housing subdivision. The facility was separated from the housing subdivision by six lanes of traffic. The facility was endorsed to care for individuals diagnosed with Alzheimer's Disease and other forms of dementia. The facility maintains a secured building to prevent residents from leaving the facility unattended. Resident #1 (R1) R1 was admitted to the facility on 07/02/24 with a diagnosis of dementia. R1 was discharged with family on 12/25/24. The facility's Active Daily Living Assessment (ADL), dated 07/02/24, documented R1 was ambulatory and was a high elopement risk. The care plan lacked documented evidence the elopement risk was addressed. Incident report dated 7/12/24 documented R1 eloped from the facility with some of their clothes. R1 went out the front door by holding the door latch for 15 seconds so the door lock would release. R1 exited to the front of the building and a caregiver caught R1 on the front sidewalk. After bringing R1 back into the facility the staff escorted R1 back to their room and R1 presented as agitated and upset. There was no documented evidence R1's care plan was updated, R1 was reassessed, or a plan was put into place to ensure R1 would not elope from the facility again after the 07/12/24 incident. Incident report dated 7/16/24 documented R1 exited out the front door by holding the door latch for 15 seconds so the door lock would release, and the door could be opened. When staff attempted to bring R1 back into the facility, R1 started hitting staff and staff were able to redirect R1 back		12/23/2024 6) Exhibit A	

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	into the building. R1 was escorted to their room and R1's Power of Attorney (POA) was notified on 7/16/24 at 6:00 PM. There was no documented evidence R1's care plan was updated, R1 was reassessed, or a plan was put into place to ensure R1 would not elope from the facility again after the 07/16/24 incident. Incident Report dated 12/23/24, documented Employee #1 (E1) observed R1 in their room approximately between 6:00 AM and 6:15 AM. The Concierge staff that monitors the front entry had not arrived for their scheduled shift which was at 8:00 AM. The incident report documented R1 eloped from the facility somewhere between 6:15 AM and 7:15 AM. R1 exited the facility by pushing the door latch for 15 seconds releasing the door to open. At the time of the incident, Employee #1 (E1) did not hear the door alarm. At 7:10 AM, a security guard from the housing subdivision across the street from the facility called the facility indicating that R1 was in their security office. Employee #2 (E2) informed the Acting Administrator (ADM) of the elopement at approximately 7:15 AM. E1 went across the street to obtain R1, however the security guard from the subdivision had notified the police who came to the subdivision and brought R1 back to the facility. Unusual incident injury report dated 12/23/24, documented R1 left the facility, and a head-to-toe assessment was completed upon the return of R1. R1 received no apparent harm from the incident and the Responsible party was notified. R1's care plan was updated to reflect elopement risk and one on one supervision was initiated. This plan was put in place after R1's three documented elopements. This plan would be in place as long as R1 was in the facility. On 01/23/25 in the morning, E1 verbalized thinking R1 was in their room and had eyes on R1 at approximately 6:00 AM, on 12/23/24. On 01/23/25 in the morning, the ADM reported prior to R1's elopement on 12/23/24, R1 eloped two other times. The ADM and			

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	E1confirmed the facility did not have a specific plan in place to keep R1 from trying to elope from the facility and to keep R1 safe knowing R1 was a high elopement risk. Facility Elopement Policy dated 12/01/23 documented if an elopement occurred the resident would be reevaluated to determine if the resident was still appropriate to be retained in the community. If the resident's physician deemed the resident could remain in the community, the resident's Person-Centered Service Plan would be adjusted, and all changes would be immediately implemented to prevent further elopements. Severity: 3 Scope: 1 FRI# 10837			