

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 A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/24/2017
NAME OF PROVIDER OR SUPPLIER PACIFICA SENIOR LIVING GREEN VALLEY			STREET ADDRESS, CITY, STATE, ZIP CODE 2620 E ROBINDALE ROAD, HENDERSON, NEVADA ,89074	
(X4) ID PREFIX TAG 0000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG 0000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Initial Comments - Inspector Comments: This Statement of Deficiencies was generated as a result of a complaint investigation conducted on your facility on 10/24/17. This State Licensure survey was conducted by the authority of NRS 449.0307, Powers of the Division of Public and Behavioral Health. The census at the time of the survey was 71. The sample size was four. There was one complaint investigated. Complaint #NV00050413 with the following allegations could not be substantiated. Allegation #1 residents being let wet for extended period of time.. Allegation #2 facility not clean. Allegation #3 roaches in the facility. Allegation #4 residents being malnutrition, dehydrated. Allegation #5 air conditioning and heating not working. The investigation into the allegations included: Observation of grooming and physical appearance for seven residents, meal observation, and a tour of the facility. Interviews were conducted with four residents, Memory Care Director and the Administrator.. Review of three files including the residents of concern. Review of the facility monthly pest control bills and job invoices. 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. There were no regulatory deficiencies identified. No further action necessary. Please retain a copy for your records.			

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

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.