

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10419	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/09/2025
NAME OF PROVIDER OR SUPPLIER GREEN VALLEY SENIOR CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 2269 ALANHURST DRIVE, HENDERSON, NEVADA ,89052		
(X4) ID PREFIX TAG RFG 0001- Deficiencies	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG RFG 0001- Deficiencies	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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. Based on an inspection conducted, the items marked below identify the violation in operation of the RFG which must be corrected by the revisit/compliance date specified in writing by the health authority. Failure to comply with this notice and immediately correct the identified deficiencies may result in the suspension or termination of your provider agreement, funding, or future authorization as a provider authorized by the State			

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: ERNIE DIAZ
REPRESENTATIVE'S SIGNATURE

Title: ADMINISTRATOR

Date: 12/14/2025

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10419	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/09/2025
NAME OF PROVIDER OR SUPPLIER GREEN VALLEY SENIOR CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 2269 ALANHURST DRIVE, HENDERSON, NEVADA ,89052		
(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
	of Nevada pursuant to NAC 433.384, and other applicable local and state laws. Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted at your facility on 12/09/25, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for ten Residential Facility for Group beds for elderly and disabled persons and/or persons with Alzheimer's disease, Category II residents. The census at the time of the survey was seven. Seven resident files and five employee files were reviewed. The facility received a grade of A. 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.			
Y 1035 SS= D	NAC 449.2768 Residential facility which provides care to persons with Alzheimer's disease: Alzheimer's/dementia Training: 1. Except as otherwise provided in subsection 2, the administrator of a residential facility which holds an endorsement as a residential facility which provides care to persons with Alzheimer's disease or other forms of dementia pursuant to NAC 449.2754 shall ensure that: (a) Each employee of the facility who has direct contact with and provides care to	Y 1035	1. Immediately after the survey, an in-house training was scheduled for E4. 2. Administrator will review and monitor at least once a month all employee folders and ensure that all requirements are in compliance. 3. Administrator has created an in-house tracker to monitor when all employee requirements are expiring and to inform employee to renew or update that requirement by expiring date. 4. Administrator is responsible in ensuring that the plan of correction is implemented. 5. On 12/13/25 E4 received her Certificate of Completion in Alzheimer's and related Dementia to satisfy the requirement pursuant to NAC 449.2754 and NAC	12/14/2025

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10419	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/09/2025
NAME OF PROVIDER OR SUPPLIER GREEN VALLEY SENIOR CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 2269 ALANHURST DRIVE, HENDERSON, NEVADA ,89052		
(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
	residents with any form of dementia, including, without limitation, dementia caused by Alzheimer's disease, successfully completes, in addition to the training required by NAC 449.196: (1) Within the first 40 hours that such an employee works at the facility after he is initially employed at the facility, at least 2 hours of tier 2 training. (2) In addition to the training requirements set forth in subparagraph (1), within 3 months after such an employee is initially employed at the facility, at least 8 hours of tier 2 training. (3) If such an employee is licensed or certified by an occupational licensing board, at least 3 hours of continuing education in providing care to a resident with dementia, which must be completed on or before the anniversary date of the first date the employee was initially employed at the facility. The requirements set forth in this subparagraph are in addition to those set forth in subparagraphs (1) and (2), may be used to satisfy any continuing education requirements of an occupational licensing board, and do not constitute additional hours or units of continuing education required by the occupational licensing board. (4) If such an employee is a caregiver, other than a caregiver described in subparagraph (3), at least 3 hours of tier 2 training in providing care to a resident with dementia, which must be completed on or before the anniversary date of the first date the employee was initially employed at the facility. The requirements set forth in this subparagraph are in addition to those set forth in subparagraphs (1) and (2). (b) The facility maintains proof of completion of the hours of training and continuing education required pursuant to this section in the personnel file of each employee of the facility who is required to complete the training or continuing education. 2. A person employed by a facility which provides care to persons with any form of dementia, including, without limitation, dementia caused by Alzheimer's disease, is not required to complete the hours of training or continuing education required		449.196. 6. Please see attached document.	

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10419	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/09/2025
NAME OF PROVIDER OR SUPPLIER GREEN VALLEY SENIOR CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 2269 ALANHURST DRIVE, HENDERSON, NEVADA ,89052		
(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
	pursuant to this section if he has completed that training within the previous 12 months. Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 5 employees obtained eight hours of Alzheimer's training within the first 90 days of employment (Employee #4). Findings include: Employee #4 was hired on 08/01/25. E4 received eight hours of Alzheimer's training on 08/02/25. E4's file lacked documented evidence E4 received an additional two hours of Alzheimer's training within the first 90 days of employment. On 12/09/25 at 10:45 AM, the House Manager was unable to provide the documentation and indicated the training was not completed. Severity: 2 Scope: 1			