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 _____	**06/04/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SWEET VALLEY HOME CARE	**6791 ELMDALE PLACE, LAS VEGAS, NEVADA ,89103**

(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 complaint investigation conducted at your facility on 06/04/24, in accordance with Nevada Administrative Code (NAC), Chapter 449, Residential Facilities for Groups. The facility is licensed for nine Residential Facility for Group beds for elderly and disabled persons, and/or Alzheimer's disease, Category II residents. The census at the time of the survey was nine. The facility received a grade of A. There were two complaints investigated. Substantiated: 1. Complaint #NV00071243 was substantiated. (See TAG Y087) Unsubstantiated: 2. Complaint #NV00070141 could not be substantiated. The investigation of the complaints included: Observation of number of residents and number of resident beds. Interviews with a Caregiver and two Co-Owners. Record review of residents, including the resident of concern. Document review of facility Policies and Procedures and Resident Admission Rental Agreement. 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: BRIAN GROSH Title: Owner Date: 06/12/2024

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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0040	Supervision of AGC - NRS 449.186 Supervision of residential facility for groups. A residential facility for groups must not be operated except under the supervision of an administrator of a residential facility for groups or a health services executive licensed pursuant to the provisions of chapter 654 of NRS. Inspector Comments: Based on observation and interview, the facility failed to notify the Division after the former Administrator resigned and did not submit an application for a new Administrator within 10 days. Findings include: On 06/04/24 in the morning, there was a current Board of Examiners for Long Term Care Administrators (BELTCA) license on the wall for an Administrator not on file with the Bureau. On 06/04/24 in the morning, the Co-Owner reported the previous Adminitrator resigned at the end of April 2024 and verbalized the BELTCA license was the new Administrator and understood all paperwork for the change of Administrator had been completed and approved. On 06/04/24, the Aithent/CLICS licensing database documented the previous Administrator as the current Administrator and no application for a change of Administrator.	0040	Correction for Tag 0040 includes submission of new administrator and license on 6/07/24. Prior administrator gave 2 week notice of resignation on 5/1/24 and new administrator took position on 5/31/24. Upon any change in administrator, there will be a submitted reguest in the portal within 10 days of resignation from administrator. Administrator who resigns will be instructed to remove license in a timely manner. Owner and administrator will ensure the future change to any administrator is done within 10 days to both HCQC and to BELTCA. Corrective action taken immediately and the new administrator was submitted to HCQC on 6/7/24.	06/07/2024

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0087 SS= F	Limitation on Number of Residents - NAC 449.199 Staffing requirements 3. A residential facility must not accept residents in excess of the number of residents specified on the license issued to the owner of the facility. Inspector Comments: Based on observation, document review and interview, the facility failed to ensure the number of residents did not exceed the specified number on the facility's license. Findings include: Review of the 2024 facility license documented the facility was licensed for nine residents. On 06/04/24 at 9:20 AM, the Caregiver reported there were 10 residents in the facility until 06/02/24 when the 10th resident passed away. On 06/04/24 at 9:20 AM, observed 10 beds with the required bedding. As of 06/04/24, there was no documented evidence the facility applied to the Bureau and updated the license for 10 beds. On 06/04/24 in the morning, the Co-Owner acknowledged there were 10 residents in the home receiving services until 06/02/24. Severity: 2 Scope: 3 Complaint #NV00071243	0087	Plan of Correction for Tag 0087 includes full understanding of Correction amount of beds currently licensed. Owner had been told by previous administrator that the facility could operate as 10 beds under the original license of 10. Owner had assumed that the downgrade to 9 beds had been reversed. Owner failed to check on HCQC portal to ensure this had been corrected. As of 05/31/24 there are 9 residents in the facility. There will be only 9 beds filled at any time and the owner will look to upgrade to 10 beds on next survey.Owner and Administrator will ensure that no admissions beyond 9 residents will occur.	06/04/2024

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0966 SS= F	Alzheimer's Care - NAC 449.2754 Residential facility which provides care to persons with Alzheimer ' s disease: Application for endorsement; general requirements. (NRS 449.0302) 3. The administrator of such a facility shall prescribe and maintain on the premises of the facility a written statement which includes: (b) Evidence that the facility has established interaction groups within the facility which consist of not more than six residents for each caregiver during those hours when the residents are awake; Inspector Comments: Based on observation and interview, the facility failed to ensure at least two Caregivers were available to provide care during the day for nine residents. Findings include: On 06/04/24 at 9:20 AM, there was one qualified Caregiver in the facility to provide care for nine residents. The Caregiver confirmed they were the only Caregiver present. On 06/04/24 in the morning, the Co-Owner confirmed there was one Caregiver on the premises. The Co-Owner acknowledged the staffing ratio of one staff member to six residents during waking hours and reported although not on site at the time the surveyor arrived at the facility, they were the backup Caregiver. Severity: 2 Scope: 3	0966	Plan of Correction for Tag 0966 includes having 2 staff present during waking hours and a back up caregiver available to cover when one calls off. On 6/4/24, a staff member called off at 7am. Owner notified, called for other staff to come in. Owner went to facility at 7:30AM to assist with morning care. Owner left facility and returned. Owner and co-owner are back up caregivers. Going forward, Owner and Administrator to be notified immediately of call off so the owner or administrator can come and be on site for the remainder of the shift. Additionally, the facility will call an agency for a caregiver in the event that both caregivers call off. All staff will receive an in-service on 6/24/24 regarding the call off reporting system and this will be included in our policy going forward.	06/04/2024

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0994 SS= F	Alzheimer 's Care Standards for Safety - NAC 449.2756 and R043-22 Residential facility which provides care to persons with Alzheimer ' s disease: Standards for safety; personnel required; training for employees. (NRS 449.0302) 1. The administrator of a residential facility which provides care to persons with Alzheimer ' s disease or other forms of dementia who meet the criteria prescribed in paragraph (a) of subsection 2 of NRS 449.1845 shall ensure that: (e) Knives, matches, firearms, tools and other items that could constitute a danger to the residents of the facility are inaccessible to the residents. Inspector Comments: Based on observation and interview, the facility failed to ensure sharp objects were secure in the facility kitchen. Findings include: On 06/04/24 at 9:30 AM, observed the following in the facility kitchen: - A knife with sharp edges in a dish drainer with other utensils, - Two drawers with a sign to keep locked were unlocked. One drawer had silverware including knives, the other had steak, butcher knives and other sharp utensils. - A third drawer had a metal shredder in it, unlocked. On 06/04/24 at 10:15 AM, the previous observation at 9:30 AM, of the unlocked drawers had not been corrected. On 06/04/24 at 10:30 AM, the Co-Owner confirmed the observation and reported the drawers should have been locked. Severity: 2 Scope: 3	0994	Plan of Correction for Tag 0994 includes proper storage and locking of kitchen knives and other equipment in the correct locked storage in cabinet or drawer. An immediate in-service was provided to staff member the same day to ensure that kitchen sharp objects including knives and equipment for cooking must be stored in the locked storage at all times when not in use by caregiver. Administrator to ensure that all staff will receive training on proper storage and locking of kitchen equipment no later than 6/24/24 to include all staff. Daily check of all kitchen equipment locked and secured to be done by evening shift each day. Owner to ensure that all locks are properly functioning.	06/04/2024