Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10902	A. BUILDING _____ B. WING _____	12/03/2024

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 an annual State Licensure survey completed at your facility on 12/03/24, 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 eight. Eight resident files and four employee 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.	0000		
0515 SS= C	Supervision and Treatment of Residents - NAC 449.259 & R043-22 Supervision and treatment of residents generally. (NRS 449.0302) 1. A residential facility shall ensure that the staff of the facility collaborate with each resident of the facility, the family of the resident and other persons who provide care for the resident, including, without limitation, a qualified provider of health care, as interpreted by section 8 of this regulation, to: (a) Develop a person-centered service plan for the resident; and (b) Review the person-centered service plan at least once each year.; Inspector Comments: Based on interview and record review, the facility failed to develop a person-centered service plan for 8 of 8 residents (Resident #1, #2, #3, #4, #5, #6, #7, and #8). Findings include: Resident #1 (R1) R1 was admitted to the facility on 05/20/23, with diagnoses including dementia and hypertension. R1's file lacked a person-centered service plan. Resident #2 (R2) R2 was admitted to the facility on 04/15/24 with diagnoses including dementia and hypertension. R2's file lacked a person-centered service plan. Resident #3 (R3) R3 was admitted to the facility on	0515	Tag 0515: to correct this deficiency, an immediate implementation of the person-centered service plan has been completed for each resident. 2. specific process change implemented to have the patient-centered service plan completed on admission and yearly thereafter. 3. To ensure this practice is completed, the Administrator will review and be responsible for regular audits of the person-centered service plan in conjunction with Hospice provider. 4. Administrator will be responsible. 5. Date corrective action completed is 12/06/2024. 6. Uploading additional supporting patient-centered service plan x nine residents.	12/06/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10902	A. BUILDING _____ B. WING _____	12/03/2024

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
	08/30/23, with diagnoses including dementia and hypertension. R3's file lacked a person-centered service plan. Resident #4 (R4) R4 was admitted to the facility on 03/18/23, with diagnoses including cardiovascular accident and hypertension. R4's file lacked a person-centered service plan. Resident #5 (R5) R5 was admitted to the facility on 11/13/24, with diagnoses including hypothyroidism and dementia. R5's file lacked a person-centered service plan. Resident #6 (R6) R6 was admitted to the facility on 07/30/24, with diagnoses including hypokalemia and hypertension. R6's file lacked a person-centered service plan. Resident #7 (R7) R7 was admitted to the facility on 08/08/24, with diagnoses including dementia and insomnia. R7's file lacked a person-centered service plan. Resident #8 (R8) R8 was admitted to the facility on 06/14/24, with a diagnoses including dementia and hypertension. R8's file lacked a person-centered service plan. On 12/03/24 in the afternoon, the House Manager acknowledged person-centered service plans were not developed for R1, R2, R3, R4, R5, R6, R7, and R8. Severity: 1 Scope: 3			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10902	A. BUILDING _____ B. WING _____	12/03/2024

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
0874 SS= E	Medication Administration-Report Received - NAC 449.2742 and R043-22 - Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 2. Within 72 hours after the administrator of the facility receives a report submitted pursuant to paragraph (a) of subsection 1, a member of the staff of the facility shall notify the resident's physician, physician assistant or advanced practice registered nurse of any concerns noted by the person who submitted the report. The report must be reviewed and initialed by the administrator. Inspector Comments: Based on record review and interview, the facility failed to ensure six-month Medication Reviews were initialed and dated by the Administrator within 72 hours for 4 of 8 residents (Residents #1, #2, #3 and #4). Findings include: Resident #1 (R1) R1 was admitted to the facility on 05/20/23, with diagnoses including dementia and hypertension. R1's file documented a medication review dated 11/06/24 and 07/17/24, the reviews lacked the initials of the Administrator and date of review. Resident #2 (R2) R2 was admitted to the facility on 04/15/24 with diagnoses including dementia and hypertension. R2's file documented a medication review dated 10/22/24, the review lacked the initials of the Administrator and date of review. Resident #3 (R3) R3 was admitted to the facility on 08/30/23, with diagnoses including dementia and hypertension. R3's file documented medication reviews dated 10/01/24 and 07/17/24, the reviews lacked the initials of the Administrator and date of review. Resident #4 (R4) R4 was admitted to the facility on 03/18/23, with diagnoses including cardiovascular accident and hypertension. R4's file documented medication reviews dated 07/17/24 and 11/03/23, the review lacked the initials of the Administrator and date of review. On 12/03/24 in the afternoon, the House Manager acknowledged the six-month Medication Reviews should have been initialed and dated by the Administrator within 72 hours for R1, R2, R3 and R4. Severity: 2 Scope: 2	0874	Tag 0874: to correct the deficiency, the administrator reviewed and signed the medication administration report for the 4 residents identified. 2. Process change with a new tracker set up to identify upcoming medication reviews and have a check-off system to be sure they are reviewed and signed timely. 3. The tracker will be reviewed and updated monthly to ensure timely reviews are completed. 4. The administrator will be responsible for this. 5. Date of corrective action taken 12/06/24. 6. Supporting documents will be uploaded to portal.	12/06/2024