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 _____	**09/08/2025**

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 completed in your facility on 09/08/25, in accordance with Nevada Administrative Code (NAC), Chapter 449, Residential Facility for Groups. The census at the time of the survey was eight. The sample size was 3. There was one complaint investigated. The facility received a grade of A. Substantiated: 1. Complaint #NV00074757 was substantiated. (See Tags Y0557, Y0830, and Y0930) The investigation of Complaints included: Observation of grooming and physical appearance for residents, interactions between staff and residents, residents in their beds, physical environment, and record storage. Interviews were conducted with residents, Caregivers, Owners, and the Administrator. Clinical Record Review of three resident files, which included the resident of concern. There were no documents reviewed. 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 deficiencies were identified:	0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Name: MICHELLE VIOLET Title: Administrator Date: 10/07/2025

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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0557 SS= D	Provision of Dental, Optical and Hearing Care - NAC 449.262 Provision of dental, optical and hearing care and social services; report of suspected abuse, neglect, isolation or exploitation; restrictions on use of restraints, confinement or sedatives. (NRS 449.0302) 3. The members of the staff of a residential facility shall not: (a) Use restraints on any resident; (b) Lock a resident in a room inside the facility; or Inspector Comments: Based on observation and interview, the facility failed to ensure bed rails were not used as a restraint for 1 of 8 residents (Resident #2). Findings include: Resident #2 (R2) R2 was admitted on 03/08/23 with diagnoses including Alzheimer's and hypertension. On 09/08/25 in the morning, R2 was observed in bed with half bed rails in the up position and was physically unable to use the bed rails for mobility related to upper extremity contractures. R2 verbalized they agreed to have half bed rails on their bed to help them with bed mobility and turning but R2 was unable to physically demonstrate their ability to use the half bed rails for bed mobility. R2's file documented an Activities of Daily Living (ADL) form dated 08/06/25 documenting R2 was completely dependent on the staff for all care including bed mobility. On 09/08/25 in the morning, the caregiver acknowledged the ROC used the full bed rails for bed mobility but was also used to prevent the ROC from falling out of the bed. On 09/08/25 in the morning, E1 verbalized R2 could not use the half bed rails for bed mobility and prevented R2 from transferring self out of bed and preventing falls, resulting in R2 being restrained in the bed. Severity: 2 Scope: 1	0557	1. To correct this specific finding: Bed rails for R2 have been removed/kept lowered and bed has been brought to low level for safety. Mat is placed below bed. 2. To ensure the deficient practice does not recur: Administrator and caregiver manager will ensure that bed rails are only in use where the resident needs them for mobility and repositioning in bed. Inservice to all caregivers to ensure bed rails are not in use and all caregivers verbalize understanding of proper use of bed rails for mobility and repositioning. 3. Administrator will review monthly, the status of all residents use of bed rails and ensure appropriate use. Ensure hospice or home care nurse reassesses patient mobility status as scheduled and more often as resident status changes. 4. The Administrator is responsible for implementing the plan of correction and ensuring the staff is educated on bedrail use. 5. Corrective action was implemented 9/10/25. Bed rails lowered and not in use. Bedfast waiver applied for.	09/10/2025
0830 SS= D	Exemption Requests - NAC 449.2736 Procedure to exempt certain residents from restrictions. (NRS 449.0302) 1. The administrator of a residential facility may submit to the Division a written request for permission to admit or retain a resident who	0830	1. To correct the specific findings: Waiver submitted for bedfast resident on 9/15/25. Waiver was provisionally approved needing additional SN schedule of visits. Resident was admitted to acute hospital shortly thereafter and the waiver was cancelled on	09/15/2025

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	is prohibited from being admitted to a residential facility or remaining as a resident of the facility pursuant to NAC 449.271 to 449.2734, inclusive. Inspector Comments: Based on observation, record review, and interview, the facility failed to ensure a medical exemption request was submitted to the Bureau and/or approved by the Bureau to retain 1 of 3 sampled residents (Resident #2). Findings include: Resident #2 (R2) R2 was admitted on 03/08/23 with diagnoses including Alzheimer's and hypertension. On 09/08/25 in the morning, R2 was observed in bed with half bed rails in the up position and was physically unable to use the bed rails for mobility related to upper extremity contractures. On 09/08/25 in the morning, R2 verbalized they agreed to have half bed rails on their bed to help them with bed mobility and turning but R2 was unable to physically demonstrate their ability to use the half bed rails for bed mobility. R2 verbalized no concerns related to their care and the facility. R2's file documented an ADL form dated 08/06/25 documenting R2 was completely dependent on the staff for all care including bed mobility. R2's file lacked evidence of observed contractures. R2's file lacked evidence of a bedfast waiver and lacked evidence of a waiver for contractures. Review of the Bureau's medical exemptions applications database revealed the facility had not submitted an application for a medical exemption for bed fast or contractures to retain R2 at the facility. On 09/08/25 in the morning, the Administrator verbalized R2's file lacked evidence of a bedfast waiver and a waiver for contractures. The Administrator verbalized they had not applied for a medical exemption waiver. Severity: 2 Scope: 1		9/26/25. Upon resident return to facility, with a new plan of care, the new waiver will be submitted again. 2. Measures or systematic changes to put in place: Administrator to ensure all residents who are considered bedfast, have a waiver on file to support this. Administrator will ensure this is submitted in a timely manner. 3. To ensure deficient practice does not recur: Administrator will review all residents on a monthly basis for any change in mobility status and if any residents are considered bedfast, a waiver will be submitted. 4. Administrator will be responsible for ensuring the plan of correction is implemented and reviewed monthly. 5. The date of corrective action: On 9/15/25 a waiver request was submitted. A new waiver request will be submitted when resident is back from the acute hospital with new plan of care for the resident.	

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0930 SS= D	Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he or she permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including, without limitation: (a) The full name, address, date of birth and social security number of the resident. (b) The address and telephone number of the resident ' s physician and the next of kin or guardian of the resident or any other person responsible for the resident. (c) A statement of the resident ' s allergies, if any, and any special diet or medication he or she requires. Inspector Comments: Based on observation, record review, and interview, the facility failed to ensure protected hospice information was properly secured. Findings include: On 09/08/25 in the morning, file binders were observed on a large bookshelf in the common area adjacent to the dining room. The files were observed in an open and accessible walkway. There was no observed restriction to access of these files. On 09/08/25 in the morning, E1 verbalized that most of their residents were on hospice services and that their records were stored in an unlocked file cabinet adjacent to the dining room. On 09/08/25 in the morning, the Owner verbalized that they were under the impression that if protected information was turned away from eyesight, that the hospice files could be stored in an unsecure area. The owner verbalized they stored all other types of files in a locked cabinet in the garage. Severity: 2 Scope: 1	0930	1. To correct the specific findings: All hospice binders for residents are to be kept in a locked cabinet. 2. Measures and systematic changes to be put in place: All Hospice binders are now in locked cabinet and Hospice providers will be provided binders when the visit. Key will be kept with lead caregiver. Education provided to all staff that the binders must be kept in locked cabinet. 3. The corrective action will be monitored by the administrator and the lead caregiver ensuring that all resident hospice binders are in a locked and secure cabinet. 4. Administrator will be responsible for ensuring the binders are kept in locked and secure cabinet going forward. 5. The corrective was completed on 9/11/25. The binders are in a locked cabinet with the resident charts.	09/11/2025