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 _____	12/02/2025

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
RFG 0001-Deficiencies	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	RFG 0001-Deficiencies		

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	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 survey completed at your facility on 12/02/25. 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 five employee files were reviewed. The facility received a grade of B.			
Y 0876 SS= D	NAC 449.2742 **Administration of medication: Responsibilities of administrator, caregiver and employees of facility.** 4. Except as otherwise provided in this subsection, a caregiver shall assist in the administration of medication to a resident if the resident needs the caregiver's assistance. A caregiver may assist the ultimate user of: (a) Controlled substances or dangerous drugs only if the conditions prescribed in subsection 6 of NRS 449.0302 are met. (b) Insulin using an auto-injection	Y 0876	This plan of correctionis not to be construed as anadmission of or agreement with thefindings and conclusions in theStatement of Deficiencies, or theproposed administrative penalty(with right to correct) on thecommunity. Rather, it is submitted asconfirmation of our ongoing efforts tocomply with all statutory and regulatoryrequirements. Inthis document, we have outlined specific actions in response to each allegationor finding. We have not presented allcontrary factual or legal arguments, nor have we identified all	12/13/2025

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	device only if the conditions prescribed in NRS 449.0304 and section 13 of this regulation are met. Inspector Comments: Based on interview and record review, the facility failed to ensure an ultimate user agreement was completed for 1 of 8 residents (Resident#3). Findings include: Resident #3 (R3) R3 was admitted on 05/23/25, with diagnoses including protein malnutrition and Alzheimer's. R3's file lacked documented evidence of a signed ultimate user agreement. On 12/02/25 in the morning, the House Manager acknowledged R3's file lacked documented evidence of a signed ultimate user agreement. Severity: 2 Scope: 1		mitigatingfactors. The facilitydesires that this plan of correction be considered the facility's allegation ofcompliance. **Y0876 Administration of Medication:Responsibilities of administrator, caregiver and employees of facility – NAC449.2742** **I. HOW TO IDENTIFYOTHER MEDICATION ISSUES** A100% audit of all resident Ultimate User Agreements has been completed toensure that each resident has a completed Ultimate User Agreement. **II. SYSTEMIC CHANGES** FacilityManager and Administrator will perform monthly audits to ensure that eachresident's Ultimate User Agreement is signed. Both Facility Manager andAdministrator will review the Ultimate User Agreement at the time of move in,as well. **III. MONITORING PROCESS** Thisprocess will be monitored by the Facility Manager by conducting on-going, monthlyaudits. **IV. DATE COMPLETION**	

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			Thisplan of correction has been completed by 12/4/2025.	
Y 0995 SS= F	**NAC 449.2756 andR043-22** (f) The facility has an area outside the facility or a yard adjacent to the facility that: (1) May be used by the residents for outdoor activities; (2) Has at least40 square feet of space for each resident in the facility; (3) Is fenced; and (4) Is maintained in a manner that does not jeopardize the safety of the residents. All gates leading from the secured, fenced area or yard to an unsecured open area or yard must be locked and keys for gates must be readily available to the members of the staff of the facility at all times Inspector Comments: Based on observation and interview, the facility failed to ensure a gate leading to the main road was properly locked and secured. Findings include: On 12/02/25 in the morning, a gate on the left side of the home, separating the back yard from the front yard and main road, was found unlocked.	Y 0995	**Y0995 NAC 449.2756 and R043-22** **I. HOW TO IDENTIFYOTHER LIFE SAFETY ISSUES** Acomplete walkthrough of the facility has been conducted to ensure that allgates leading from the secured, fenced area or yard to an unsecured open areaare locked at all times. **II. SYSTEMIC CHANGES** FacilityManager and Administrator conduct daily walkthroughs to ensure that these locksare in place and working properly **III. MONITORING PROCESS** Thisprocess will be monitored by the Facility Manager and Administrator byconducting on-going monthly audits. **IV. DATE COMPLETION** Thisplan of correction has been completed by 12/4/2025.	12/13/2025

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	On 12/02/25 in the morning, the House Manager confirmed the gate on the left side of the home, which led to the street, was left unlocked. Severity: 2 Scope: 3			
Y 1825 SS= E	**NAC 449.0109 Designation and training of person responsible for infection control.** 3. The program to prevent and control infections within the facility for the dependent developed pursuant to paragraph (a) of subsection 1 must provide for the designation of: (a) A primary person who is responsible for infection control; and (b) A secondary person who is responsible for infection control when the primary person is absent to ensure that someone is responsible for infection control at all times. 4. The persons designated pursuant to subsection 3 as responsible for infection control shall complete not less than 15 hours of training concerning the control and prevention of infections provided by the Association for Professionals in Infection Control and Epidemiology, Inc., the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the World Health Organization or the Society for Healthcare Epidemiology of America, or a successor in interest to any of those organizations, not later than 3 months after being designated and annually thereafter. 5. Training completed pursuant to subsection 4 may be in any format,	Y 1825	**Y1825 NAC 449.0109 Designation andtraining of person responsible for infection control** **I. HOW TO IDENTIFYOTHER HR FILE ISSUES** A100% audit of all employee files has been completed to ensure that there is aprimary and secondary infection control manager. As of 12/1/2025, a newinfection control manager has been designated (Nicholas Kittle) and hasreceived his 15 hour infection control training. **II. SYSTEMIC CHANGES** FacilityManager and Administrator will ensure that both the primary and secondaryinfection control managers have completed annual infection control training. **III. MONITORING PROCESS** Thisprocess will be monitored by the Facility Manager and Administrator byconducting on-going monthly audits. **IV. DATE COMPLETION** Thisplan of correction has been completed	12/13/2025

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	including, without limitation, an online course provided for compensation or free of charge. A certificate of completion for the training must be maintained in the personnel file of each person designated pursuant to subsection 3 for 3 years immediately following the completion of the training. Inspector Comments: Based on record review and interview, the facility failed to ensure the primary infection control staff member completed 15 hours of infection control training annually (Employee #1). Findings include: Employee #1 (E1) was hired on 04/20/24 as the Administrator. E1 was identified as the primary infection control manager for the facility. E1's file revealed 15 hours of infection control training was last completed on 07/31/24. On 12/02/25 in the morning, the House Manager confirmed 15 hours of infection control training had not been completed by the primary infection control manager since 07/31/24. Severity: 2 Scope:2		by 12/2/2025.	
Y 1700 SS= E	**NRS 449.1845** **Administrator of residential facility for groups to conduct annual assessment of history of each resident and cause provider of health care to conduct certain examinations and assessments; placement**	Y 1700	**Y1700 NRS 449.1845** **I. HOW TO IDENTIFYOTHER RESIDENT FILE ISSUES** A100% audit of all resident files has been completed to ensure that allresidents have	12/13/2025

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	based on assessment. 1. The administrator of a residential facility for groups shall: (a) Annually cause a qualified provider of health care to conduct a physical examination of each resident of the facility; (b) Annually conduct an assessment of the history of each resident of the facility, which must include, without limitation, an assessment of the condition and daily activities of the resident during the immediately preceding year; and (c) Cause a qualified provider of health care to conduct an assessment of the condition and needs of a resident of the facility to determine whether the resident meets the criteria prescribed in paragraph (a) of subsection 2: (1) Upon admission of the resident to the facility; and (2) If a physical examination, assessment of the history of the resident or the observations of the administrator or staff of the facility, the family of the resident or another person who has a relationship with the resident indicate that: (I) The resident may meet those criteria; or (II) The condition of the resident has significantly changed.		a signed initial placement assessment. **II. SYSTEMIC CHANGES** FacilityManager and Administrator will ensure that prior to move in, each new residenthas a signed initial placement assessment completed.. **III. MONITORING PROCESS** Thisprocess will be monitored by the Facility Manager and Administrator byconducting on-going monthly audits. IV. DATE COMPLETION Thisplan of correction has been completed by 12/2/2025.	

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	2. If, as a result of an assessment conducted pursuant to paragraph (c) of subsection 1, the provider of health care determines that the resident: (a) Suffers from dementia to an extent that the resident may be a danger to himself or herself or others if the resident is not placed in a secure unit or a facility that assigns not less than one staff member for every six residents, any residential facility for groups in which the resident is placed must meet the requirements prescribed by the Board pursuant to subsection 2 of NRS 449.0302 for the licensing and operation of residential facilities for groups which provide care to persons with Alzheimer's disease or other severe dementia. (b) Does not suffer from dementia as described in paragraph (a), the resident may be placed in any residential facility for groups. 3. As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031. (Added to NRS by 2019, 2594) Inspector Comments:			

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	Based on record review and interview, the facility failed to ensure an initial placement assessment was obtained for 2 of 8 residents (Resident #2, and Resident #3). Findings include: Resident #2 (R2) R2 was admitted on 07/15/25 with diagnoses including hyponatremia and muscle weakness. R2's resident file lacked documented evidence of an initial physician placement assessment. Resident #3 (R3) R3 was admitted on 05/23/25 with diagnoses including protein/calorie malnutrition and Alzheimer's. R3's resident file lacked documented evidence of an initial physician placement assessment. On 12/02/25 in the morning, the House Manager acknowledged R2's and R3's resident files lacked documented evidence of an initial physician placement assessment. Severity: 2 Scope:2			
Y 1540 SS= D	**NAC 449.011931and R004-24** NAC 449.011931 Cultural competency training for agent or employee who provides care to patient or resident. (NRS 449.0302, 449.103) 1. Except as otherwise provided in NRS 449.103, as amended by section 1 of Assembly Bill No. 267, chapter 202, Statutes of Nevada 2023, at page 1176, a facility shall provide cultural competency training through an approved course or program to an agent or employee described	Y 1540	**Y1540 NAC 449.011931 and R004-24** **I. HOW TO IDENTIFYOTHER HR ISSUES** A100% audit of all employee files has been completed to ensure that all employeehave a current Cultural Competency training.	12/13/2025

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	in subsection 2 of NRS 449.103, as amended by section 1 of Assembly Bill No. 267, chapter 202, Statutes of Nevada 2023, at page 1176: (a) Within 90 days after contracting with or hiring the agent or employee; (b) At least biennially thereafter. Such biennial training must consist of at least 2 hours of instruction each biennium. 2. The facility may provide the training required by subsection 1 over several instructional periods or during a single instructional period so long as the agent or employee: (a) Completes the hours of cultural competency training required by subsection 1 and the entire contents of the course or program; and (b) Receives a certificate of completion on or before the date on which subsection 1 requires the agent or employee to complete the cultural competency training. 3. Except as otherwise provided in subsection 4, the facility shall keep documentation in the personnel file of an agent or employee of the facility or a record of an agent or employee in the relevant electronic system of the facility proof of the completion of the cultural competency training required pursuant to NRS 449.103, as amended by section 1 of Assembly Bill No. 267, chapter 202, Statutes of Nevada 2023, at page 1176. 4. If an agent or employee of a facility is exempt from the requirement to complete cultural competency training pursuant to subsection 3 of NRS 449.103, as amended by section 1 of Assembly Bill No. 267, chapter 202, Statutes of Nevada 2023, at page 1176, the facility shall maintain proof in the personnel file of the agent or employee or a record of the agent or employee in the relevant electronic system of the facility that the agent or employee holds a valid professional license, registration or certificate, as applicable, for which the continuing education described in subsection 3 of NRS 449.103, as amended by section 1 of Assembly Bill No. 267, chapter 202, Statutes of Nevada 2023, at page 1176, is required for renewal.		**II. SYSTEMIC CHANGES** FacilityManager and Administrator will ensure that upon hire, each new employeereceives state approved cultural competency training, and received trainingbi-annually thereafter. **III. MONITORING PROCESS** Thisprocess will be monitored by the Facility Manager and Administrator byconducting on-going monthly audits. **IV. DATE COMPLETION** Thisplan of correction has been completed by 12/2/2025.	

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	Inspector Comments: Based on interview and record review, the facility failed to ensure Cultural Competency training was completed for 1 of 5 Employees (Employee#2) Findings include: Employee #2 (E1) was hired on 04/28/23 as a Caregiver. Review of E2's record revealed E2's last completed Cultural Competency training on 04/24/23. On 12/02/25 in the morning, the House Manager confirmed there was no current Cultural Competency training on file for Employee #2 in 2025. Severity: 2 Scope: 1			