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 _____	01/14/2026

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 a complaint investigation survey initiated at your facility on 01/14/26. The census at the time of the survey was 8. Five resident files and two employee files were reviewed. The facility received a grade of A. There were two complaints investigated. Unsubstantiated: 1. Complaint #12796 could not be substantiated. No regulatory deficiencies could be identified. 2. Complaint #12664 could not be substantiated. No regulatory deficiencies could be identified. The investigation into the complaints included: Interviews were conducted with the House Manager, Residents and Hospice CNA. Clinical Record Review of five			

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	records, which included the resident of concern. Document review of agency policies and procedures and employee records. 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 deficiency was identified.			
Y 0065 SS= D	**NAC 449.196 & R043-22** **Qualifications of caregivers:** 1. A caregiver of a residential facility must: (a) Be at least 18 years of age; (b) Be responsible and mature and have the personal qualities which will enable him or her to understand the problems of elderly persons and persons with disabilities; (c) Understand the provisions of NAC 449.156to 449.27706,inclusive, *and sections 2 to 16,inclusive, of this regulation* and sign a statement that he or she has read those provisions; (d) Demonstrate the ability to read, write, speak and understand the English	Y 0065	**Y 0065 NAC 449.196 & R043-22Qualifications of caregivers** **I. HOW TO IDENTIFYOTHER HR FILE ISSUES** A100% audit of all employee files has been completed to ensure that eachemployee has been trained to properly use a Hoyer Lift safely. **II. SYSTEMIC CHANGES** FacilityManager and Administrator will	01/20/2026

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	language; (e) Possess the appropriate knowledge, skills and abilities to meet the needs of the residents of the facility; and *(f) Not later than 60 days after commencing employment with the residential facility, receive not less than 4 hours of a combination of tier 1 and tier 2 training related to care for the residents of the facility;* and *(g)*Receive annually not less than 8 hours of training related to providing for the needs of the residents of a residential facility. Such training *must include, without limitation, at least 2 hours of tier 2 training.* Inspector Comments: Based on observation and interview, the facility failed to ensure employees received training to operate a Hoyer lift for 1 of 5 residents (Resident #1). Findings include: Resident #1 (R1) R1 was admitted on 9/24/25 with a diagnosis of hypertension, hyperlipidemia and history of cochlear implant. On 01/14/26 in the afternoon, a Hoyer lift was observed in the family room in the facility. According to the House Manager, the Hoyer lift was utilized to transfer a resident from bed to shower chair and family room recliner chair.		ensure that this training is completed for eachemployee upon hire, and 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 1/20/2026.	

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	On 01/14/26 in the afternoon, R1 explained the caregivers utilized the Hoyer lift to assist them out of bed. On 01/14/26 in the afternoon, the House Manager verbalized staff members have been trained on how to operate the Hoyer lift by the previous Administrator. The House Manager acknowledged the facility had no documented evidence onsite that employees had been trained in the use of the Hoyer lift and should have. Severity: 2 Scope: 1			