STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2758	A. BUILDING _____ B. WING _____	04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY MEMORY CARE	8880 W TROPICANA AVE, LAS VEGAS, NEVADA ,89147-6000

(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 and complaint investigation completed in your facility on 04/07/26. The facility is licensed for 72 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 three. Three resident files and two employee files were reviewed. The facility received a grade of B. The census at the time of the survey was 65. The sample size was 15. There were three complaints and one Facility Reported Incident (FRI) investigations. Substantiated without deficient Practice: 1. Complaint #13246 was substantiated with no deficient practice.			

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	Unsubstantiated: 2. Complaint #13068 could not be substantiated. No regulatory deficiencies could be identified. 3. Complaint #13230 could not be substantiated. No regulatory deficiencies could be identified. 4. Complaint #13243 could not be substantiated. No regulatory deficiencies could be identified. The investigation into Complaints and FRIs included: Observation of grooming and physical appearance for residents, resident to resident interactions, and a tour of the facility. Interviews were conducted with residents, Caregivers, Med Techs, the Resident Care Coordinator, and the Executive Director. Clinical Record Review of 15 records, which included the resident's concern. Document Review included facility policy and procedures, and incident reports.			
Y 0102 SS= D	NAC 449.200 and R043-22	Y 0102	Whencompleting your Plan of Correction you must address all of the following:	05/18/2026

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	(d) The health certificates required pursuant to Chapter 441A of NAC for the employee. Inspector Comments: Based on interview and record review, the facility failed to ensure an employee had completed a physical and two-step Tuberculosis (TB) test upon hire for 1 of 8 employees (Employee #1). Findings include: Employee #1 (E1) E1 was hired by the facility on 09/10/25 as a caregiver. E1's employee file lacked documented evidence E1 had completed a physical and two-step TB test upon hire. On 04/07/26 in the afternoon, the Executive Director was informed of and acknowledged if E1's physical and proof of a two-step TB test was not received by the State of Nevada Bureau of Health Care Quality and Compliance (HCQC) by 12pm on 04/09/26 it would be assumed E1 had not completed a physical or two-step TB test and it would result in a citation. On 04/09/26 the requested		1) How you will correct the specific finding(s) stated inthe Statement of Deficiencies (MUST ADDRESS); **Email was sent as attached within thetimeframe allotted. Community was/is auditing all employee files to ensure allhealth records and required training have been completed and documented.** 2) What measures or systematicchange(s) will be put into place to ensure the deficient practice does notrecur (MUST ADDRESS); **Onceaudit is complete, all files have been logged in a tracker. The tracker will bemonitored to ensure compliance** 3) How the corrective action(s)will be monitored to ensure the deficient practice will not recur (MUSTADDRESS); **Onceaudit is complete, all files have been logged in a tracker. The tracker will bemonitored to ensure compliance** 4) The title of the person(position) responsible for ensuring the plan of correction is implemented (DONOT INCLUDE PERSONAL NAMES, JUST USE THE TITLE or POSITION) (MUST ADDRESS); **ED and BOM** 5) The date the corrective action will be completed (MUSTINCLUDE); AND **5/18/2026** 6) You must attach all supporting documents into the system(MUST INCLUDE). **attached** 7) How you will identify and correct other areas havingpotential to be affected by the same deficient practice(if applicable) **as in #1**	

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	documentation for E1 had not been received. Severity: 2 Scope: 1			
Y 0106 SS= D	NAC 449.0113 2. The personnel file for a caregiver of a residential facility must include, in addition to the information required pursuant to subsection 1: (a) A certificate stating that the caregiver is currently certified to perform first aid and cardiopulmonary resuscitation. Inspector Comments: Based on interview and record review the facility failed to ensure an employee had completed training to perform cardiopulmonary (CPR) resuscitation for 1 of 8 employees (Employee #2). Findings include: Employee #2 (E2) E2 was hired by the facility on 07/12/21 as a Caregiver. E2's employee file lacked documented evidence E2 had completed training to perform CPR training.	Y 0106	Whencompleting your Plan of Correction you must address all of the following: 1) How you will correct the specific finding(s) stated inthe Statement of Deficiencies (MUST ADDRESS**); Email was sent as attached within thetimeframe allotted. Community was/is auditing all employee files to ensure allhealth records and required training have been completed and documented.** 2) What measures or systematicchange(s) will be put into place to ensure the deficient practice does notrecur (MUST ADDRESS); **Onceaudit is complete, all files have been logged in a tracker. The tracker will bemonitored to ensure compliance** 3) How the corrective action(s)will be monitored to ensure the deficient practice will not recur (MUSTADDRESS); **Onceaudit is complete, all files have been logged in a tracker. The tracker will bemonitored to ensure compliance** 4) The title of the person(position) responsible for ensuring the plan of correction is implemented (DONOT INCLUDE PERSONAL NAMES, JUST USE THE TITLE or POSITION) (MUST ADDRESS); **ED and BOM** 5) The date the corrective action will be completed (MUSTINCLUDE); AND **5/18/2026** 6) You must attach all supporting documents into the system(MUST INCLUDE). **attached** 7) How you will identify and correct other areas havingpotential to be affected by the same deficient practice(if applicable) **as in #1**	05/18/2026

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	On 04/07/26 in the afternoon, the Executive Director was informed of and acknowledged if E2's CPR certification was not received by the State of Nevada Bureau of Health Care Quality and Compliance (HCQC) by 12pm on 04/09/26 it would be assumed E2 had not completed CPR training, and it would result in a citation. On 04/09/26 at 12pm, documentation verifying E2 had completed CPR training was not received. Severity: 2 Scope: 1			

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Y 0255 SS= D	NAC 449.217 6. A residential facility with **more than 10 residents** must: (a) Comply with the standards prescribed in chapter 446 of NAC; and (b) Obtain the necessary permits from the Division. 7. The equipment used for cooking and storing food and for washing dishes in a residential facility with more than 10 residents must be inspected and approved by the Division and the state and local fire safety authorities. Inspector Comments: Based on observation on 04/07/2026, the facility failed to ensure the kitchen and supportive dining services complied with the standards of NAC 446. Findings include: 1. Major Violations: a. The interior of the microwave in one serving kitchen was heavily soiled with food debris. b. Multiple resident personal food items were not labeled or dated in both serving kitchen refrigerators. Severity: 2 Scope: 1	Y 0255	1) How you will correct thespecific finding(s) stated in the Statement of Deficiencies (MUST ADDRESS **Microwave in field sidesub kitchen was cleaned thoroughly. All staff retrained to ensure compliance** 2) What measures or systematicchange(s) will be put into place to ensure the deficient practice does notrecur (MUST ADDRESS);**FSD and RSD will monitor cleanliness daily and re- train as needed** 3) How the corrective action(s)will be monitored to ensure the deficient practice will not recur (MUSTADDRESS); **FSDand RSD will monitor cleanliness daily and re- train as needed** 4) The title of the person(position) responsible for ensuring the plan of correction is implemented (DONOT INCLUDE PERSONAL NAMES, JUST USE THE TITLE or POSITION) (MUST ADDRESS); **RSD and FSD** 5) The date the corrective action will be completed (MUSTINCLUDE); AND **4/7/26** 6) You must attach all supporting documents into the system(MUST INCLUDE). **n/a** 7) How you will identify and correct other areas havingpotential to be affected by the same deficient practice(if applicable) **#2**	04/07/2026

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Y 0994 SS= F	**NAC 449.2756** **Residential facility which provides care to persons with Alzheimer's disease: Standards for safety; personnel required;** (e) Knives, matches, firearms, tools, and other items that could constitute a danger to the residents of the facility are inaccessible to the residents. (g) All toxic substances are not accessible to the residents of the facility. Inspector Comments: Based on observation and interview, the facility failed to ensure toxic substances were not accessible to residents. Findings include: On 04/07/26 in the morning, the door to the laundry room in the E hall of the facility was left unlocked and an unlocked cabinet revealed a Clorox cleaning spray bottle. On 04/07/26 in the morning, the Maintenance Manager acknowledged the toxic substance was unsecured and should have been locked. Severity: 2 Scope:3	Y 0994	1) How you will correct the specific finding(s) stated in the Statement of Deficiencies (MUST ADDRESS **Chemical was brought in by staff. They were re-trained regarding usage of approved cleaning products and the liquid was destroyed. The door was repaired so that it would close properly to ensure cleaning products are locked.** 2) What measures or systematic change(s) will be put into place to ensure the deficient practice does not recur (MUST ADDRESS);**All community directors will monitor resident areas for hazardous substancesand ensure doors are closing and locking properly** 3) How the corrective action(s)will be monitored to ensure the deficient practice will not recur (MUSTADDRESS); **All administrative staff will monitor daily and re- train as needed** 4) The title of the person(position) responsible for ensuring the plan of correction is implemented (DONOT INCLUDE PERSONAL NAMES, JUST USE THE TITLE or POSITION) (MUST ADDRESS); **ED, MD, RSD, FSD** 5) The date the corrective action will be completed (MUSTINCLUDE); AND **4/7/26** 6) You must attach all supporting documents into the system(MUST INCLUDE). **n/a** 7) How you will identify and correct other areas havingpotential to be affected by the same deficient practice(if applicable) **#2**	04/07/2026
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	Y 1540	Whencompleting your Plan of Correction you must address all of the following: 1) How you will correct the specific finding(s) stated inthe Statement of Deficiencies (MUST ADDRESS**); Email was sent as attached within thetimeframe allotted. Community was/is auditing all employee files to ensure allhealth records and required training have been completed and documented.** 2) What measures or systematicchange(s) will be put into place to ensure the deficient practice does notrecur (MUST ADDRESS); **Onceaudit is complete, all files have been logged in a tracker.**	05/18/2026

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	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 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		**The tracker will bemonitored to ensure compliance** 3) How the corrective action(s)will be monitored to ensure the deficient practice will not recur (MUSTADDRESS); **Onceaudit is complete, all files have been logged in a tracker. The tracker will bemonitored to ensure compliance** 4) The title of the person(position) responsible for ensuring the plan of correction is implemented (DONOT INCLUDE PERSONAL NAMES, JUST USE THE TITLE or POSITION) (MUST ADDRESS); **ED and BOM** 5) The date the corrective action will be completed (MUSTINCLUDE); AND **5/18/2026** 6) You must attach all supporting documents into the system(MUST INCLUDE). **attached** 7) How you will identify and correct other areas havingpotential to be affected by the same deficient practice(if applicable) **as in #1**	

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	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. Inspector Comments: Based on interview and record review the facility failed to ensure employees had completed cultural competency training for 2 of 8 employees (Employee #1 and Employee #2). Findings include: Employee #1 (E1) E1 was hired by the facility on 09/10/25 as a Caregiver. E1's employee file lacked documented evidence E1 completed cultural competency training. E2 was hired by the facility on 09/10/25 as a Caregiver. E2's employee file lacked documented evidence E2 completed cultural competency training. On 04/07/26 in the afternoon, the executive director was informed of and acknowledged to provide documentation to the Bureau verifying cultural competency training for E1 and E2 was completed by 12pm on 04/09/26.			

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	On 04/09/26 at 12pm, documentation verifying E1 and E2 had completed cultural competency training had not been received. Severity: 2 Scope: 1			