

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3363	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/02/2021
NAME OF PROVIDER OR SUPPLIER SPRING VALLEY ALZ CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6428 CRYSTAL DEW DRIVE, LAS VEGAS, NEVADA ,89118		
(X4) ID PREFIX TAG 0000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG 0000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual state licensure and infection control survey conducted at your facility on 12/02/21, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facilities for Groups. The facility is licensed for ten Residential Facility for Group beds for the elderly and disabled and/or persons with Alzheimer's disease and/or chronic illness, Category II residents. The census at the time of the survey was eight. Eight resident files and two employee files were reviewed. The facility received a grade of A. The facility was provided guidance on the requirements of NRS 449.101 - Discrimination prohibited; development of antidiscrimination policy; posting of nondiscrimination statement and certain other information, NRS 449.102 - Duties of licensed facility to protect privacy of patient or resident, and LCB File No. R016-20 - Cultural competency training; complaint policy; development of gender identity/expression policy; designated person responsible for compliance with these regulations. Failure to comply with NRS 449.101, NRS 449.102 and LCB File No. R016-20 may result in future deficiencies. 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:			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER Name: BRAD BOMAN Title: Administrator Date: 12/11/2021
REPRESENTATIVE'S SIGNATURE

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3363	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/02/2021
NAME OF PROVIDER OR SUPPLIER SPRING VALLEY ALZ CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6428 CRYSTAL DEW DRIVE, LAS VEGAS, NEVADA ,89118		
(X4) ID PREFIX TAG 0050 SS= F	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Administrator's Responsibilities - Oversight - NAC 449.194 Responsibilities of administrator. (NRS 449.0302) The administrator of a residential facility shall: 1. Provide oversight and direction for the members of the staff of the facility as necessary to ensure that residents receive needed services and protective supervision and that the facility is in compliance with the requirements of NAC 449.156 to 449.27706, inclusive, and chapter 449 of NRS. Inspector Comments: Based on observation and interview, the facility failed to ensure infection control practices were implemented and maintained in response to the COVID-19 pandemic. Findings include: On 12/02/21 in the morning, the facility did not check the temperature of the health facilities inspector (HFI) prior to entry to the facility or conduct a questionnaire about COVID-19 symptoms and travel history. Caregiver #2 answered the door without wearing a face mask. On 12/02/21, in the morning, Caregiver #1, Caregiver #2, and the Owner acknowledged temperatures checks and COVID-19 screening questionnaires should have been asked to the HFI prior to entry into the facility, and Caregiver #2 should have been wearing a face mask. Severity: 2 Scope: 3	ID PREFIX TAG 0050	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) The Visitor Log that will be used has been uploaded. All Visitors will be checked at the front door. Temperatures will be taken and Questions listed on the second document uploaded will be asked and the form filled out and saved. The owner and Administrator will review the Log and Questionnaire weekly to assure the info is being gathered correctly and for everyone. Staff will be given an In-service by the Owner to make sure they understand how and why this is needed.	(X5) COMPLETION DATE 12/11/202 1

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3363	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/02/2021
NAME OF PROVIDER OR SUPPLIER SPRING VALLEY ALZ CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6428 CRYSTAL DEW DRIVE, LAS VEGAS, NEVADA ,89118		
(X4) ID PREFIX TAG 0936 SS= D	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG 0936	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE 12/11/2021
	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: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 8 residents met the requirements concerning tuberculosis (TB) testing in accordance with Nevada Administrative Code (NAC) 441A. (Resident #3). Findings include: Resident #3 (R3) R3 was admitted to the facility on 04/08/20, with diagnoses including hypertension, lung diseases, alcoholism, and heart disease. R3's initial TB 2-step testing was completed on 04/02/20 with a negative result. R3's file lacked documented evidence an annual one-step TB test was completed in 2021. On 12/02/21, in the morning, Caregiver #1 and the Owner acknowledged R3's file lacked documented evidence of a one-step annual TB test completed in 2021. Severity: 2 Scope: 1		A TB test is attached. It was done on 12/06/21. The Results are not yet available. The Quantiferon - Gold blood test takes a little bit longer. WE are in touch with the Lab to make sure we have the results as soon as possible. The Owner will review the Resident Files Monthly to insure the Testing is done as needed and when needed.	

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3363	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/02/2021
NAME OF PROVIDER OR SUPPLIER SPRING VALLEY ALZ CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6428 CRYSTAL DEW DRIVE, LAS VEGAS, NEVADA ,89118		
(X4) ID PREFIX TAG 0995 SS= F	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Alzheimer 's Care Standards for Safety - NAC 449.2756 Residential facility which provides care to persons with Alzheimer ' s disease: Standards for safety; personnel required; training for employees. (NRS 449.0302) 1. The administrator of a residential facility which provides care to persons with Alzheimer ' s disease shall ensure that: (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 least 40 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 an outside exit gate was locked and secured. Findings include: On 12/02/21, in the morning, during a tour of the facility, an exit gate was observed in the back yard unlocked and not secured. Caregiver #1 and the Owner acknowledged the exit gate did not have a lock and was unsecured. Severity: 2 Scope: 3	ID PREFIX TAG 0995	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) A picture of the Gate is attached. A lock is affixed to the upper part of the Gate. The Key to the Gate will be placed for all Staff to use if & when it is needed. The Owner will check the gate on a regular basis to be sure the Lock is present and locked.	(X5) COMPLETION DATE 12/10/202 1