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 |
|---|---|---|---|
| | 3363 | A. BUILDING _____ B. WING _____ | 12/05/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SPRING VALLEY ALZ CARE CENTER | 6428 CRYSTAL DEW DRIVE, LAS VEGAS, NEVADA ,89118 |

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| 0000 | Initial Comments<br><br>Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure survey completed at your facility on 12/05/23 in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for 10 Residential Facility for Group beds for elderly and disabled persons and/or persons with Alzheimer's disease and/or persons with Chronic Disease, Category II residents. The census at the time of the survey was ten. Ten resident files and five employee files were reviewed. The facility received a grade of A. 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 regulatory deficiencies were identified: | 0000 | | |

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| 0106 SS= D | Personnel File - 1st Aid & CPR - NAC 449.200 Personnel files 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;<br><br>Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 5 employees met the requirements for cardiopulmonary resuscitation (CPR) and first aid training (Employee #2). Findings include: Employee #2 (E2) E2 was hired on 08/13/19 as a Caregiver. E2's last CPR and first aid training was completed online on 09/15/23. E2's file lacked documented evidence E2 completed CPR training in person, per the requirement. On 12/05/23 in the afternoon, E2 explained CPR and first aid training was completed online without the in-person training component required. On 12/05/23 in the afternoon, the Administrator was unable to provide documented evidence of in-person CPR and first aid training for E2. Severity: 2 Scope: 1 | 0106 | 1.) Citation will be corrected by having Employee #2 attend in-person First Aid/CPR training and obtaining certification.<br><br>2.) Administrator and ownership will evaluate any completed First Aid/CPR training for staff in order to ensure that it was done in-person and not online, in order to satisfy State regulatory compliance.<br><br>3.) Administrator will notify ownership and staff that First Aid/CPR training must be done in-person. Administrator will monitor the facility staff's First Aid/CPR training, and upon renewal dates, ensure that they are completed in-person.<br><br>4.) Administrator will monitor for compliance.<br><br>5.) Corrective action taken 12/23/2023. | 12/23/2023 |

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| 0178 SS= E | Health & Sanitation - Maintain Int/ext - NAC 449.209 Health and sanitation. (NRS 449.0302) 5. The administrator of a residential facility shall ensure that the premises are clean and that the interior, exterior and landscaping of the facility are well maintained.<br><br>Inspector Comments: Based on observation and interview, the Administrator failed to ensure the ceilings and walls were maintained. Findings include: On 12/05/23 in the morning, areas in need of repair in three resident rooms were observed: - The ceiling in Room 9/10 was observed to have sustained water damage. The water damage exposed missing layers of ceiling, plaster, wood, and other structures underneath. - Room 8 had holes in the wall and was missing sections of paint where a wheelchair had scraped the paint away. - Room 3 had bulges in the ceiling due to water damage, and cracks in the paint where the ceiling and wall met. The Administrator and the Caregiver acknowledged the bulges and cracks in the ceiling. On 12/05/23 in the morning, the Caregiver acknowledged the holes in the wall and the loss of paint in Room 8 and attributed it to damage from a wheelchair. On 12/05/23 in the afternoon, the Owner explained the water damage in Room 9/10 was from when the air conditioner (AC) had a leak. The AC had been repaired but the damage the AC leak had caused to the ceiling in the resident rooms had not been repaired. The Administrator reported they were looking for a reliable person to fix the damage. Severity: 2 Scope: 2 | 0178 | 1.) Corrective action will be taken by coordinating with a repair man to fix the cited damage. A repair man by the name of Chris De Jesus has been hired to repair the water damage. He can be reached at 702-338-8804.<br><br>Ceiling in Room 9/10 was repaired on 12/22/23 (see attached picture). Damages in Rooms 3 and 8 were repaired on 12/31/23.<br><br>2.) Administrator and ownership will speak with staff, residents, and resident family members to notify them of the need to point out any damage to the facility that may be hazardous or negatively affect the services provided by the facility. Administrator, ownership, staff, residents, and resident family members will monitor for any concerning damage to the facility that will need to be promptly repaired.<br><br>3.) Administrator will walk through the facility upon each visit to look out for any damage that will need to be repaired. Ownership will also be monitoring the facility for repairable damages.<br><br>4.) Administrator will monitor for compliance.<br><br>5.) Corrective action taken 12/21/2023. | 12/21/2023 |

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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<br><br>Inspector Comments: Based on observation and interview, the facility failed to ensure half bed rails were not being used as restraints to prevent falls for 2 of 10 residents (Residents #3 and #7). Resident #3 (R3) R3 was admitted on 08/01/22 with diagnoses including cerebral infarction, seizures, and dysphagia. On 12/05/23 in the morning, R3 was observed lying in bed with the half bed rail raised. The Caregiver indicated the rail was used to prevent the resident from falling out of bed. The Caregiver reported R2 could not get out of bed independently. R2 appeared to be asleep throughout the observation and during the interview with the Caregiver. Resident #7 (R7) R7 was admitted on 12/06/21 with diagnoses including sepsis, Parkinson's Disease, and primary hypertension. On 12/05/23 in the morning, R7 was observed lying in bed with the half bed rail raised. The Caregiver reported the rail was up for R7's safety, since R7 got aggravated while dreaming, and could fall out of bed. On 12/05/23 in the morning, the Caregiver acknowledged the half bed rails for R3 and R7 were used to keep them from falling out of bed, and the Administrator acknowledged bed rails should not be used as restraints. Severity: 2 Scope: 1 | 0557 | 1.) Corrective action will be taken by putting the half-rails down on the beds for Residents #2 and #7, and instituting other fall safety measures.<br><br>2.) Staff and ownership will be notified by Administrator that half-rails may only be used as an assistance for residents for mobility purposes, not for restraint purposes.<br><br>3.) Administrator and ownership will monitor resident beds for half-rail use upon each visit.<br><br>4.) Administrator will monitor for compliance.<br><br>5.) Corrective action taken 12/5/2023. | 12/05/2023 |
| 0870 SS= D | Medication Administration-Accuracy & Report - NAC 449.2742 Administration of medication: Responsibilities of administrator, caregiver and employees of facility. 1. The administrator of a residential facility that provides assistance to residents in the administration of medications shall: (a) Ensure that a physician, pharmacist or registered nurse who does not have a financial interest in the facility: (1) Reviews for accuracy and appropriateness, at least | 0870 | 1.) Corrective action will be taken by having Resident #5's physician sign the aforementioned Medication Review list. Signature was obtained on 12/8/2023.<br><br>2.) Administrator will evaluate, more thoroughly, all resident Medication Review lists for any added instructions that the facility must follow.<br><br>3.) Administrator will have staff notify | 12/08/2023 |

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| | once every 6 months the regimen of drugs taken by each resident of the facility, including, without limitation, any over-the-counter medications and dietary supplements taken by a resident; and (2) Provides a written report of that review to the administrator of the facility. (b) Include a copy of each report submitted to the administrator pursuant to paragraph (a) in the file maintained pursuant to NAC 449.2749 for the resident who is the subject of the report. (c) Make and maintain a report of any actions that are taken by the caregivers employed by the facility in response to a report submitted pursuant to paragraph (a).<br><br>Inspector Comments: Based on record review and interview, the facility failed to ensure a physician was notified of a pharmacist's recommendations on a 6-month medication review for 1 of 10 residents (Resident #5). Findings include: Resident #5 (R5) R5 was admitted on 04/28/20 with diagnoses including chronic obstructive pulmonary disease, dysarthria following cerebral infarction, and Type 2 Diabetes Mellitus. R5's medication review was conducted by a pharmacist on 11/14/23, and signed off by the Administrator. The pharmacist made recommendations on the report. There was no documented evidence the physician was contacted about the recommendations. On 12/05/23 in the afternoon, the Caregiver was unable to provide documented evidence of a physician's review of the document, and the Administrator acknowledged a physician should have been made aware of the pharmacist's recommendations on R5's medication review. Severity: 2 Scope: 1 | | Administrator of any completed resident Medication Review documents as they occur. Administrator will evaluate each one personally for any discrepancies or extra instructions.<br><br>4.) Administrator will monitor for compliance.<br><br>5.) Corrective action taken 12/8/2023. | |