

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3729	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/09/2023
NAME OF PROVIDER OR SUPPLIER SPRING VALLEY ALZHEIMERS CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5310 SHARON MARIE COURT, 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 survey completed at your facility on 02/09/23, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for eight Residential Facility for Group beds for elderly and disabled persons and/or persons with Alzheimer's disease, Category II residents. The census at the time of the survey was five. Five resident files and three 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:			

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: PAUL A AQUINO Title: Administrator Date: 02/28/2023
REPRESENTATIVE'S SIGNATURE

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0072 SS= F	Qualifications of Caregiver - Med Training - NAC 449.196 Qualifications and training of caregivers. (NRS 449.0302) 3. If a caregiver assists a resident of a residential facility in the administration of any medication, including, without limitation, an over-the-counter medication or dietary supplement, the caregiver must: (a) Before assisting a resident in the administration of a medication, receive the training required pursuant to paragraph (e) of subsection 6 of NRS 449.0302, which must include at least 16 hours of training in the management of medication consisting of not less than 12 hours of classroom training and not less than 4 hours of practical training, and obtain a certificate acknowledging the completion of such training; (b) Receive annually at least 8 hours of training in the management of medication and provide the residential facility with satisfactory evidence of the content of the training and his or her attendance at the training; (c) Complete the training program developed by the administrator of the residential facility pursuant to paragraph (e) of subsection 1 of NAC 449.2742; and (d) Annually pass an examination relating to the management of medication approved by the Bureau. Inspector Comments: Based on record review and interview, the facility failed to ensure 3 of 3 Caregivers received annual medication management training (Employee #1, #2, and #3's were hired as Caregivers. All employee's annual medication management training expired on 01/04/23 and lacked documented evidence of training in 2023. The Administrator acknowledged the employees had not had annual medication management training in 2023. Severity: 2 Scope: 3	0072	1) All caregivers will be taking the annual medication training. 2) Continuing education trainings along with medication management trainings will be arranged and scheduled at least one month before certificate expires. 3 & 4) The Administrator will set up appointments with training personal at least one month before the certificate expires for annual training. 5) completed on 2/1/2023 6) Documents #1,2, and 3 included.	02/10/2023

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(X4) ID PREFIX TAG 0102 SS= D	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG 0102	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE 02/23/2023
	Personnel File - TB Screening - NAC 449.200 Personnel files. 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (d) The health certificates required pursuant to chapter 441A of NAC for the employee; Inspector Comments: Based on record review and interview, the facility failed to ensure 1 of 3 employees had an annual tuberculosis (TB) test. Employee #2 was hired on 03/04/03 as a Caregiver. The employee file documented a TB test was completed on 04/28/21. Employee #2 acknowledged an annual TB test was not completed in 2022. Severity: 2 Scope: 1		1) Employee #2 will be given an annual TB Test. 2) An employee checklist will be created and posted in the medication and employee file station. List will show dates of TB Tests, Fingerprinting , dates, continuing education credits. 3 & 4) The administrator will be in charge of keeping TB Tests, fingerprinting, CEU's Current. 5) completed on 2/23/23 6) Document #4 included.	