STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	3729	A. BUILDING _____ B. WING _____	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY ALZHEIMERS CARE	5310 SHARON MARIE COURT, LAS VEGAS, NEVADA ,89118

(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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	3729	A. BUILDING _____ B. WING _____	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY ALZHEIMERS CARE	5310 SHARON MARIE COURT, LAS VEGAS, NEVADA ,89118

(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
	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 State Licensure survey completed at your facility on 03/04/26, 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 four. Four resident files and three employee files were reviewed. The facility received a grade of A.			
Y 0620 SS= F	**NAC 449.2702** **Written policy on admissions required; age and other eligibility requirements.** 4. Except as otherwise provided in NAC 449.275 AND 449.2754, a residential facility shall not admit or allow to remain in the facility any person who: (a) Is bedfast; (b) Requires restraint; (c) Requires confinement in locked quarters; or (d) Requires skilled nursing or other medical supervision on a 24-hour basis. 6. As used in this section:	Y 0620	1) Residents 1,2,3, and 4 have applications for their Bed Fast Waiver submitted. 2) Future Residents will have Bedfast Waivers applied upon admittance. 3 & 4) The administrator will notify the bureau when a new admittance requires a waiver. 5) Waiver has been applied for on 3/13/26, result pending . 6) Attachments A-D	03/13/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	3729	A. BUILDING _____ B. WING _____	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY ALZHEIMERS CARE	5310 SHARON MARIE COURT, LAS VEGAS, NEVADA ,89118

(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
	(a) “Bedfast” means a condition in which a person is: (1) Incapable of changing his position in bed without the assistance of another person; or (2) Immobile. (b) “Restraint” means: (1) A psychopharmacologic drug that is used for discipline or convenience and is not required to treat medical symptoms; (2) A manual method for restricting a resident’s freedom of movement or his normal access to his body; or (3) A device or material or equipment which is attached to or adjacent to a resident’s body that cannot be removed easily by the resident and restricts the resident’s freedom of movement or his normal access to his or her body. 5. A person may not reside in a residential facility if the person’s physician or the Bureau determines that the person does not comply with the requirements for eligibility. Inspector Comments: Based on observation, interview and record review, the facility failed to obtain a waiver to retain residents who are bedfast, for 4 of 4 residents (Resident #1, Resident #2, Resident #3 and Resident #4). Findings include: Resident #1 (R1) R1 was admitted on 02/16/26 with			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	3729	A. BUILDING _____ B. WING _____	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY ALZHEIMERS CARE	5310 SHARON MARIE COURT, LAS VEGAS, NEVADA ,89118

(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
	diagnoses including respiratory failure and hypertension. On 03/04/26 in the morning, R1 was observed lying on their back in bed. R1 was unable to demonstrate ability to turn on their side without staff assistance. Resident #2 (R2) R2 was admitted on 12/31/25 with diagnoses including sacral pressure sore and heart failure. On 03/04/26 in the morning, R2 was observed lying on their back in bed. R2 was unable to demonstrate ability to turn on their side and indicated they could only turn with staff assistance. Resident #3 (R3) R3 was admitted on 09/30/20 with diagnoses including cerebral vascular accident and contractures of the right hand and foot. On 03/04/26 in the morning, R3 was observed lying on their back in bed. R3 was unable to demonstrate ability to turn on their side and indicated they could only turn on their side with assistance from staff. Resident #4 (R4) R4 was admitted on 02/16/21 with diagnoses including Alzheimer's disease and Downs syndrome. On 03/04/26 in the morning, R4 was observed lying on their back in bed. R4 was unable to demonstrate ability to turn on their side without staff assistance. Review of R1, R2, R3 and R4's medical records did not document a bedfast waiver for R1, R2, R3 or R4. On 03/04/26 in the morning, the Administrator revealed R1, R2, R3 and R4 could not turn in bed without staff assistance and confirmed the facility did not have a bedfast waiver for R1, R2, R3 or R4.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	3729	A. BUILDING _____ B. WING _____	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY ALZHEIMERS CARE	5310 SHARON MARIE COURT, LAS VEGAS, NEVADA ,89118

(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
	Severity: 2 Scope: 3			
Y 0770 SS= D	**NAC 449.2724 Residents having contractures.** 1. A person who has contractures must not be admitted to a residential facility or be permitted to remain as a resident of a residential facility unless the contractures do not adversely affect the ability of the resident to perform normal bodily functions and: (a) The resident is able to care for the contractures without assistance; or (b) Supervision in caring for the contractures is provided by a medical professional who is trained to provide such supervision. 2. The caregivers employed by a residential facility with a resident who has contractures shall ensure that the performance by the resident of any exercises to improve the resident's range of motion or any other exercises prescribed by a physician is supervised by a medical professional who has been trained to provide such supervision. Inspector Comments: Based on observation, interview and record review, the facility failed to obtain a waiver to retain a resident with contractures, for 1 of 4 residents (Resident #3). Findings include: Resident #3 (R3) was admitted on 09/30/20	Y 0770	1) Resident #3 has an application for contractures Submitted 2) Future Residents will have waiver if they have contractures. 3 & 4) The administrator will inform the bureau when a new contracture admittance requires a waiver. 5) Waiver Applied for on 3/13/26. Results Pending.	03/13/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	3729	A. BUILDING _____ B. WING _____	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY ALZHEIMERS CARE	5310 SHARON MARIE COURT, LAS VEGAS, NEVADA ,89118

(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
	with diagnosis including cerebral vascular accident and contractures of the right arm and foot. On 03/04/26 in the morning, R3 was observed lying in bed with contractures of the right hand. R3 revealed they had contractures of both the right hand and right foot. Review of R3's medical record documented R3 had contractures of the right hand and foot but did not reveal a documented waiver to retain R3 in the facility. On 03/04/26 in the morning, the Administrator confirmed R3 had contractures and the facility did not have a waiver for R3 to remain in the facility. Severity: 2 Scope: 1			
Y 0820 SS= D	**NAC 449.2734** **Residents having tracheostomy or open wound requiring treatment by a medical professional; residents having pressure or stasis ulcers.** 1. A person who has a tracheostomy or an open wound that requires treatment by a medical professional must not be admitted to a residential facility or be permitted to remain as a resident of a residential facility unless: (a) The wound is in the process of healing or the tracheostomy is stable or can be cared for by the resident without assistance; (b) The care is provided by or under the supervision of a medical professional who has been trained to provide that care; or	Y 0820	1) Resident #2 has an application for a pressure sore submitted. 2) Future residents with wounds or pressure sores will have a waiver applied. 3 & 4) The administrator will inform the bureau when a person with wounds requires a waiver. 5) Waivers applied for on 3/13/26. Results pending.	03/13/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	3729	A. BUILDING _____ B. WING _____	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY ALZHEIMERS CARE	5310 SHARON MARIE COURT, LAS VEGAS, NEVADA ,89118

(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
	(c) The wound is the result of surgical intervention and care is provided as directed by the surgeon. 2. If a person who has a pressure or stasis ulcer or who is at risk of developing a pressure or stasis ulcer is admitted to a residential facility or permitted to remain as a resident of a residential facility: (a) The condition must have been diagnosed by a physician; (b) The condition must be cared for by a medical professional who is trained to provide care for and reassessment of that condition; and (c) Before a caregiver provides care to a person who has a pressure or stasis ulcer or who is at risk of developing a pressure or stasis ulcer, the caregiver must receive training related to the prevention and care of pressure sores from a medical professional who is trained to provide care for that condition. 3. The administrator of the facility shall ensure that records of the care provided to a person who has a pressure or stasis ulcer pursuant to subsection 2 are maintained at the facility. The records must include an explanation of the cause of the pressure or stasis ulcer. Inspector Comments: Based on interview and record review, the facility failed to obtain a waiver to retain a resident with a pressure sore, for 1 of 4 residents (Resident #2). Findings include: R2 was admitted on 12/31/25 with diagnoses including sacral pressure sore			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	3729	A. BUILDING _____ B. WING _____	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY ALZHEIMERS CARE	5310 SHARON MARIE COURT, LAS VEGAS, NEVADA ,89118

(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
	and heart failure. On 03/04/26 in the morning, R2 acknowledged they had a pressure sore on their lower back. Review of R2's physical exam, dated 12/15/25, documented R2 had a stage III decubitus ulcer on the coccyx and lateral legs. There was no documentation of a wound waiver found in the record of R2. Hospice records documented wound care was being provided. On 03/04/26 in the morning, the Administrator acknowledged R2 had pressure sores on their lower back and both legs and confirmed they had not obtained a wound waiver to retain R2 in the facility. Severity: 2 Scope: 1			