

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5954	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/17/2025
NAME OF PROVIDER OR SUPPLIER SPRUCE OAK RESIDENTIAL CARE FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 4618 SPRUCE OAK DR, NORTH LAS VEGAS, NEVADA ,89031		
(X4) ID PREFIX TAG RFG 0001- Deficiencies	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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	ID PREFIX TAG RFG 0001- Deficiencies	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

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: JESSICA COBB
REPRESENTATIVE'S SIGNATURE

Title: Executive Director

Date: 11/27/2025

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5954	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/17/2025
NAME OF PROVIDER OR SUPPLIER SPRUCE OAK RESIDENTIAL CARE FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 4618 SPRUCE OAK DR, NORTH LAS VEGAS, NEVADA ,89031		
(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 11/17/25, in accordance with Nevada Administrative Code (NAC) Chapter 449, Residential Facility for Groups. The facility is licensed for six Residential Facility for Group beds for elderly and disabled persons and/or persons with mental illness, Category II residents. The census at the time of survey was five. Five resident files and five employee files were reviewed. The facility received a grade of A .			
Y 0515 SS= D	NAC 449.259 Supervision of residents. 1. A residential facility shall ensure that the staff of the facility collaborate with each resident of the facility, the family of the resident and other persons who provide care for the resident, including, without limitation, a qualified provider of health care, as interpreted by section 8 of this regulation, to: (a) Develop a person-centered service plan for the resident; and (b) Review the person-centered service plan at least once each year. 2. A person-centered service plan developed pursuant to this section must	Y 0515	1. A care plan was created for Resident #5 on November 17, 2025. 2. A new care plan template was created for all new resident admissions. 3. All new residents will have a care plan created on admission. 4. The group home manager will ensure all residents have a care plan and that is updated.	11/17/2025

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5954	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/17/2025
NAME OF PROVIDER OR SUPPLIER SPRUCE OAK RESIDENTIAL CARE FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 4618 SPRUCE OAK DR, NORTH LAS VEGAS, NEVADA ,89031		
(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
	include, without limitation: (a) Provisions concerning activities of daily living, medication management, cognitive safety, assistive devices, special needs, social and recreational needs and involvement of ancillary services; (b) Protective supervision as necessary for the resident; (c) The manner in which all caregivers will be informed of the required supervision of the resident; (d) The manner in which the facility will ensure that the resident has the opportunity to attend the religious service of his or her choice and participate in personal and private pastoral counseling; (f) Permission for the resident to enter or leave the facility at any time if the resident: (1) Is physically and mentally capable of leaving the facility; and (2) Complies with the rules established by the administrator of the facility for leaving the facility; (g) Laundry services for the resident unless the resident elects in writing to make other arrangements; (h) The manner in which the facility will ensure that the resident's clothes are clean, comfortable and presentable; (i) A requirement that the facility must inform the resident or his or her representative of the actions that the resident should take to protect the resident's valuables; (j) A written program of activities for the resident that includes scheduled and unscheduled activities that are suited to his or her interests and capacities; Inspector Comments: Based on interview and record review, the facility failed to develop a care plan for 1 of 5 residents (Resident #5). Findings include: Resident #5 (R5) was admitted on 09/03/24 with diagnosis including seizure disorder			

Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 5954	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/17/2025
NAME OF PROVIDER OR SUPPLIER SPRUCE OAK RESIDENTIAL CARE FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 4618 SPRUCE OAK DR, NORTH LAS VEGAS, NEVADA ,89031		
(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 hypertension. Review of R5's medical record revealed a care plan had not been developed or implemented for R5. On 11/17/25 in the morning, a Caregiver confirmed the facility had not completed a care plan for R5. Severity: 2 Scope: 1			
Y 1840 SS= D	R063-21 Sec. 4. Sec. 4. 1. An unlicensed caregiver who provides care to residents, patients or clients at a facility described in section 3 of this regulation shall annually complete evidence-based training provided by a nationally recognized organization concerning the control of infectious diseases. The training must include, without limitation, instruction concerning: (a) Hand hygiene; (b) The use of personal protective equipment, including, without limitation, masks, respirators, eye protection, gowns and gloves; (c) Environmental cleaning and disinfection; (d) The goals of infection control; (e) A review of how pathogens, including, without limitation, viruses, spread; and (f) The use of source control to prevent pathogens from spreading. 2. Each unlicensed caregiver who completes the training required by subsection 1 must provide proof of completion of that training to the administrator or other person in charge of the facility in which the unlicensed caregiver provides care. Inspector Comments: Based on interview and document review, the facility failed to ensure infection control training for unlicensed caregivers was completed annually, for 2 of 5 employees (Employee #2 and Employee #4). Findings include: Employee #2 (E2)	Y 1840	1. Employee #4 and employee #2 will have infection control training completed by December 1, 2025. 2. All care staff will be required to complete infection control training upon hire and annually. 3. Employee files will be audited quarterly to ensure proper infection control training compliance. 4. The group home manager will monitor to ensure compliance.	12/01/202 5

STATE FORM Event ID: Facility ID: Page 5 of 5