STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11251	A. BUILDING _____ B. WING _____	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALAGE SENIOR LIVING AT CARSON VALLEY	973 IRONWOOD DRIVE, MINDEN, NEVADA ,89423

(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
	11251	A. BUILDING _____ B. WING _____	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALAGE SENIOR LIVING AT CARSON VALLEY	973 IRONWOOD DRIVE, MINDEN, NEVADA ,89423

(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 a complaint investigation completed in your facility on 01/14/2026. The census at the time of the survey was 60. The sample size was 5. There was one complaint investigated. Complaint #12650 could not be substantiated. No regulatory deficiencies could be identified. The investigation of the complaint included: Observations of staff-to-resident interactions and call light response times. Interviews were conducted with residents, Caregivers, the Business Office Manager, the Director of Health and Wellness, the Journey Director, the Memory Care Director, and the Executive Director. Clinical Record Review of five resident records included physician orders, service plans, and medication administration records. Document review included five resident records included physician orders, service plans, and medication administration records.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11251	A. BUILDING _____ B. WING _____	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALAGE SENIOR LIVING AT CARSON VALLEY	973 IRONWOOD DRIVE, MINDEN, NEVADA ,89423

(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
Y 0106 SS= D	NAC 449.0113 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. Inspector Comments: Based on personnel record review and interview, the facility failed to ensure 1 of 5 sampled employees were certified to perform first aid and cardiopulmonary resuscitation (Employee #1). Findings include: Employee #1 Employee #1 was hired by the facility as a Medication Technician with a start date of 05/01/2025. Employee #1's personnel record lacked documentation of CPR certification. On 01/14/2026 at 1:45 PM, the Health and Wellness Director (HWD) explained all staff should be CPR certified and the HWD confirmed Employee #1's clinical record lacked documentation of CPR certification. Severity: 2 Scope:1	Y 0106	Employee (Med Tech) was immediately contacted on 1/14/26 and removed from the schedule. Employee/Med Tech took the med tech class on 1/17/26 and med tech certificate is now current (until 2028). The Business Office Director implemented a spreadsheet tracker containing expiration dates of med tech certifications to ensure all med tech's attend renewal class well ahead of the expiration date.	01/17/2026
Y 0515 SS= F	NAC 449.259	Y 0515	**1) How the facility will correct the specific finding(s) stated in the Statement of Deficiencies:**	03/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11251	A. BUILDING _____ B. WING _____	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALAGE SENIOR LIVING AT CARSON VALLEY	973 IRONWOOD DRIVE, MINDEN, NEVADA ,89423

(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
	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 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		The five (5) resident service plans identified during the inspection have been reviewed, revised and updated to ensure compliance with NAC 449.259 requirements for person-centered service plans. Each service plan has been updated to include, as applicable: • Activities of Daily Living (ADLs) • Medication management • Cognitive safety needs • Assistive devices • Individualized special needs and concerns • Social and recreational needs • Ancillary services • Protective supervision Each plan now specifies the method by which caregivers are informed of required supervision through resident-specific daily task sheets. In addition:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11251	A. BUILDING _____ B. WING _____	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALAGE SENIOR LIVING AT CARSON VALLEY	973 IRONWOOD DRIVE, MINDEN, NEVADA ,89423

(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
	or her interests and capacities; Inspector Comments: Based on record review and interview and clinical record review, the facility failed to develop person-centered service plans for 5 of 5 sampled residents. Findings include: The clinical records for 5 of 5 sampled residents lacked person-centered service plans to reflect each residents' care needs. On 01/14/26 1:45 PM, the Health and Wellness Director (HWD) confirmed the facility used a template for the person-centered service plans and the HWD confirmed the templates were not updated to accurately reflect the residents' care needs. Severity: 2 Scope: 3		• Service plans reflect that each resident is provided the opportunity to attend **religious or spiritual services** of their choice. • Each plan documents the resident's ability to enter and exit the facility, based on physical and cognitive status and in accordance with facility policy. • **Laundry and housekeeping services** are included, with specified frequency. • Residents and/or their representatives are informed, upon admission, of procedures to safeguard valuables, including the use of locked storage within their unit. **2) What measures or systemic change(s) will be put into place to ensure the deficient practice does not recur:** The facility has implemented the following systemic changes to ensure ongoing compliance: • All service plans will be developed using a **person-centered planning process**, based on: ◦ Physician's report ◦ Comprehensive assessment	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11251	A. BUILDING _____ B. WING _____	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALAGE SENIOR LIVING AT CARSON VALLEY	973 IRONWOOD DRIVE, MINDEN, NEVADA ,89423

(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
			completed by the Health and Wellness Director and/or Memory Care Director ◦ Resident and/or family input, including preferences and life history • Service plans will be reviewed and updated at the following intervals: ◦ Upon admission ◦ Within 30 days of admission ◦ At least quarterly (every three months) ◦ With any significant change in condition ◦ • Each service plan will include: ◦ Individualized interventions ◦ Alignment with assessment findings ◦ Identification of behavioral and psychosocial needs ◦ An activity program both scheduled and unscheduled tailored to the resident's preferences **3) How the corrective action(s) will be monitored to ensure the**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11251	A. BUILDING _____ B. WING _____	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALAGE SENIOR LIVING AT CARSON VALLEY	973 IRONWOOD DRIVE, MINDEN, NEVADA ,89423

(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
			deficient practice will not recur: The facility will implement the following monitoring processes: • Quarterly care conferences conducted by the Health and Wellness Director and/or Memory Care Director with the resident and responsible party to review accuracy, completeness, and continued appropriateness of each resident's individualized service plan • Continual oversight audits conducted by the Executive Director • Immediate correction of any identified deficiencies, including staff re-education as indicated • Ongoing documentation of audit findings for Quality Assurance and Performance Improvement (QAPI) purposes **4) The title of the person (position) responsible for ensuring the Plan of Correction is implemented:** • Health and Wellness Director • Memory Care Director • Executive Director •	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11251	A. BUILDING _____ B. WING _____	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALAGE SENIOR LIVING AT CARSON VALLEY	973 IRONWOOD DRIVE, MINDEN, NEVADA ,89423

(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
			These positions are responsible for ensuring implementation, compliance, and ongoing monitoring of all individual service plans. **5) The date the corrective action will be completed:** The five (5) service plans identified during the inspection have been reviewed and updated as of March 23, 2026. In addition, A facility-wide review of all remaining service plans is in progress. **6) You must attach all supporting documents into the system:** The five (5) corrected service plans have been uploaded to the licensing portal as of March 23, 2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11251	A. BUILDING _____ B. WING _____	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALAGE SENIOR LIVING AT CARSON VALLEY	973 IRONWOOD DRIVE, MINDEN, NEVADA ,89423

(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
			7) How the facility will identify and correct other areas having potential to be affected by the same deficient practice: A comprehensive, facility-wide audit of all resident service plans is being conducted by the Health and Wellness Director, the Memory Care Director and oversight by the Executive Director to identify, correct and update any additional deficiencies related to personalized/individualized service plans.	