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
	3729	A. BUILDING _____ B. WING _____	02/08/2022

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
0000	Initial Comments Inspector Comments: This Statement of Deficiencies was generated as a result of an annual State Licensure and infection control survey conducted in your facility on 02/08/22, 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 or disabled persons and/or 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. The facility was provided guidance on the requirements of NRS 449.101 - Discrimination prohibited; development of antidiscrimination policy; posting of nondiscrimination statement and certain other information, NRS 449.102 - Duties of licensed facility to protect privacy of patient or resident, and LCB File No. R016-20 - Cultural competency training; complaint policy; development of gender identity/expression policy; designated person responsible for compliance with these regulations. Failure to comply with NRS 449.101, NRS 449.102 and LCB File No. R016-20 may result in future deficiencies. 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		

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 REPRESENTATIVE'S SIGNATURE Name: PAUL A AQUINO Title: Administrator Date: 02/15/2022

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0620 SS= D	Written Policy on Admissions - NAC 449.2702 Written policy on admissions; eligibility for residency. (NRS 449.0302) 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. Inspector Comments: Based on observation, interview and record review, the facility failed to ensure a resident who was bedfast was not allowed to remain in the facility for 1 of 4 residents (Resident #1). Resident #1 (R1) was unable to demonstrate the ability to turn themselves in bed without assistance. There was no approved bedfast medical exemption in R1's file. The Administrator confirmed R1 required assistance to turn in bed and did not have a medical exemption to remain in the facility. Severity: 2 Scope: 1	0620	1) All residents who are incapable of turning or repositioning themselves without assistance will have a bedfast waiver obtained. 2) Upon admitting, an assessment will be conducted if the resident is able to perform some range of motion to reposition. A totally motionless person will not be admitted. 3)The administrator will be responsible for obtaining the waiver. Documentation from resident #1's (RI) Hospice has been forwarded to BHCQC for review. (Attachment 1-5) 4) Completion by Feb 16, 2022	02/15/2022
0859 SS= D	Medical Care of Resident After Illness - NAC 449.274 Medical care of resident after illness, injury or accident; periodic physical examination of resident; rejection of medical care by resident; written records. (NRS 449.0302) 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by his or her physician. The resident must be cared for pursuant to any instructions provided by the resident ' s physician. Inspector Comments: Based on interview and record review, the facility failed to ensure a physical exam was completed annually for 1 of 4 residents (Resident #4). Resident #4 (R4's) last physical exam was completed on 01/14/21. The Administrator acknowledged the last physical exam for R4 was conducted over a year ago. Severity: 2 Scope: 1	0859	1) Residents physical records should be checked on a monthly basis as to when an updated physical is to take place. 2) The dates of the residents physical shall be noted on the current MAR (Medication Administration Records) to serve as a reminder. Physicians Offices and Hospice Agencies who are involved with the resident will be notified a month in advance when the physical is due. 3) The administrator will be responsible in arranging for Resident #4s (R4) Physical . (Attachment #6-7) 4) Completion date Feb 11,2022.	02/15/2022

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0938 SS= D	Maintenance and Contents of Separate File - NAC 449.2749 Maintenance and contents of separate file for each resident; confidentiality of information. (NRS 449.0302) 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he or she permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including, without limitation: (g) An evaluation of the resident ' s ability to perform the activities of daily living and a brief description of any assistance he or she needs to perform those activities. The facility shall prepare such an evaluation: (1) Upon the admission of the resident; (2) Each time there is a change in the mental or physical condition of the resident that may significantly affect his or her ability to perform the activities of daily living; and (3) In any event, not less than once each year. Inspector Comments: Based on interview and record review, the facility failed to ensure an Activities of Daily Living (ADL) assessment was completed annually for 1 of 4 residents (Resident #2). Resident #2 (R2's) ADL's were last assessed on 10/01/20. The Administrator acknowledged an ADL assessment had not completed for R2 in over a year. Severity: 2 Scope: 1	0938	1) Resident's ADL assessment shall be done upon admittance. 2) Annual ADL assessment for the residents will be done in January regardless of what month the resident was admitted in the previous year. 3) The administrator is responsible for doing the annual ADL assessment for Resident #2 (R3) (attachment #8-9) 4 R2's Annual assessment is completed on Feb 12, 2022	02/12/2022