STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295095	A. Building B. Wing	08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandstone Spring Valley	5650 South Rainbow Blvd Las Vegas, NV 89118

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure the air conditioning unit in 2 of 12 resident room halls (1300 Hall and 2300 Hall) was maintained in good working condition. The deficient practice had the potential for the temperature to be at an uncomfortable level. Findings include: The Resident Council Meeting Minutes dated 06/10/2025, with ten residents in attendance, documented the residents had complained the air conditioning was not working in the Valley of Fire Unit and Mount [NAME] Unit. There were cooling fans throughout the building, but it did not alleviate the situation.Review of the facility map revealed the Valley of Fire Unit (located on the first floor of the building) consisted of resident rooms in 1100 Hall, 1200 Hall, and 1300 Hall. Mount [NAME] Unit (located on the second floor of the building) had the residents' rooms in 2100 Hall, 2200 Hall, and 2300 Hall.On 08/21/2025 at 12:15 PM, a Certified Nursing Assistant (CNA) revealed in June 2025 the air conditioning in some of the rooms on the first and second floor of the building was shut down and not working. The CNA indicated it was hot in the affected resident rooms. The CNA confirmed the residents were complaining about the hot room temperature.On 08/21/2025 at 2:44 PM, the Director of Nursing (DON) indicated Resident 181 (R181) was transferred from room [ROOM NUMBER] to room [ROOM NUMBER] on 05/28/2025 at 2:10 PM due to complaint of warm temperature in the room.R181 was admitted on [DATE] and discharged on 06/07/2025. The Nurse's Notes dated 05/28/2025 at 2:11 PM, documented room change to 2608 from 2201.On 08/22/2025 at 11:07 AM, the Administrator indicated in June 2025 an electric power surge in the building which shutdown the air conditioning unit in 1300 Hall and 2300 Hall. There were 12 private rooms in each hall or a total of 24 private rooms for the two halls. The facility called the contracted Heating, Ventilation, and Air Conditioning (HVAC) company immediately. The HVAC company came out servicing the air conditioning and was able to reset the system to make the air conditioning worked. The Administrator revealed after the repair, the system (air conditioning unit) was shutting down and needed to reset again. The Administrator explained the Maintenance Director kept on resetting the system every two hours to have the air conditioning work.The Administrator indicated electric fans and portable air conditioning units were provided to mitigate the situation. The Administrator confirmed the 1300 Hall, and 2300 Hall were closed on 07/12/2025 and had not been used since then.The Administrator acknowledged the temperature in the resident rooms should have been between 72 to 82 degrees Fahrenheit. The Administrator indicated the temperature in the resident rooms was 83 to 84 degrees Fahrenheit when the air conditioning was shut down.The Administrator explained the facility provided portable swamp coolers (evaporative coolers) in all affected rooms. The Administrator indicated it was an ongoing process and the needed parts for the repair of the air conditioning arrived yesterday (08/21/2025). The Administrator confirmed the contracted HVAC company was currently at the facility today and working to install the parts.On 08/22/2025 at 11:44 AM, the Maintenance Director indicated the residents remained in the affected rooms no longer than three days in June 2025 when the air conditioning was shut down and not working.On 08/22/2025 at 2:30 PM, the DON confirmed R181's room upon admission (room [ROOM NUMBER]) was affected by the air conditioning being shut down. The DON indicated there were individual rooms aside from the rooms in 1300 Hall and 2300 Hall which were affected. On 08/22/2025 at 2:48 PM, the Administrator indicated around 17 residents in 1300 Hall and 2300 Hall could have been affected by the hot room temperature when the air conditioning was not working and shut down in June 2025. The Administrator explained five residents opted to stay in the unit. The Administrator revealed 1300 Hall, and 2300 Hall had 12 private rooms each, or a total of 24 rooms, with 90-95% occupancy rate.The Administrator provided a timeline of events regarding the issue with the air conditioning unit which documented the following:- On approximately 06/01/2025, the facility experienced a power surge which damaged one indoor air unit. The contracted HVAC company was notified and was onsite the same day to review and provide repairs.- While repairing the individual unit, a communication error occurred causing one of six hallways on the first floor and one of six hallways on the second floor to experience intermittent outages.- System was able to be reset same day. The system worked for approximately ten days before a wiring issue caused the system to shut down.- Facility maintenance staff were on site and able to manually reset the air conditioning unit in question. This corrected the issue but only temporarily. The air conditioning system continued to shut down approximately every two hours. Maintenance staff stayed onsite and would manually reset the system as needed.- Approximately 06/10/2025, the contracted HVAC company identified