

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS3543AGZ	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/13/2009
NAME OF PROVIDER OR SUPPLIER COTTAGES OF GREEN VALLEY		STREET ADDRESS, CITY, STATE, ZIP CODE 2620 E ROBINDALE ROAD HENDERSON, NV 89074		
(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) COMPLETE DATE
Y 000	<p>Initial Comments</p> <p>This Statement of Deficiencies was generated as a result of a complaint state licensure survey conducted at your facility on 1/13/09.</p> <p>The survey was conducted using Nevada Administrative Code (NAC) 449, Residential Facility Groups Regulations, adopted by the Nevada State Board of Health on July 14, 2006.</p> <p>The facility was licensed for 103 total beds.</p> <p>The facility had the following category of classified beds: Alzheimer's Category 2 - 55 beds and Category 2 - 48 beds.</p> <p>The facility had the following endorsements: Residential facility which provides care to elderly and/or disabled persons and/or persons with Alzheimer's Disease.</p> <p>The census at the time of the survey was 84. Twelve residents were interviewed and 2 employee were interviewed.</p> <p>There was 1 complaint investigated during the survey. Complaint #NV000020459 - Substantiated (Tag Y0086)</p> <p>The findings and conclusions of any investigation by the Health Division 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.</p> <p>The following regulatory deficiencies were identified:</p>	Y 000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 086	Continued From page 1	Y 086		
Y 086 SS=F	<p>449.199(2) Staffing-More than 20 residents</p> <p>NAC 449.199 2. Except as otherwise provided in NAC 449.2756, the administrator of a residential facility which has more than 20 residents shall ensure that at least one employee is awake and on duty at the facility at all times. An additional employee must be available to provide care within 10 minutes after he is informed that his services are needed.</p> <p>This Regulation is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide an additional employee to be available to provide care within 10 minutes after the employee was informed services were needed during the night shift hours between 10:00PM and 6:00AM.</p> <p>Severity: 2 Scope: 3</p>	Y 086		

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