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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure fingernail care was provided for 4 of 40 sampled residents (Resident 10, 13, 12 and 9). The deficient practice had the potential for residents not to receive nail care. Findings include:1) Resident 10 (R10) was admitted on [DATE], with diagnoses including cerebral infarction and dependence on a respirator.On 08/19/2025 at 10:51 AM, R10 was observed lying in bed and noted to have bilateral hand contractures. The fingernails on both hands were approximately more than a quarter of an inch long. Two wound care nurses confirmed the long fingernails. The two wound care nurses indicated certified nursing assistants (CNAs) were responsible for providing fingernail care. 2) Resident 13 (R13) was admitted on [DATE], with diagnoses including chronic respiratory failure and tracheostomy.On 08/19/2025 at 11:33 AM, R13 was observed lying in bed and noted to have bilateral hand contractures. The fingernails on both hands were approximately more than a quarter of an inch long. Two wound care nurses confirmed the long fingernails.3) Resident 12 (R12) was admitted on [DATE], with diagnoses including urinary tract infection and infection/inflammation reaction due to other urinary catheter.On 08/19/2025 at 11:42 AM, R12 was observed lying in bed and noted to have bilateral hand contractures. The fingernails on both hands were approximately a quarter of an inch long. The nursing supervisor came to assess R12's fingernails and agreed that the resident needs nail care. The nursing supervisor indicated fingernail care could be provided by both nurses and CNAs. Fingernail length and the need for trimming should be assessed during shower days.4) Resident 9 (R9) was admitted on [DATE], with diagnoses including anoxic brain damage and dependence on a respirator.On 08/19/2025 at 11:31 AM, R9 was observed lying in bed and noted to have bilateral hand contractures. The fingernails on both hands were approximately a quarter of an inch long. Two wound care nurses confirmed the long fingernails.On 08/21/2025 at 3:15 PM, a Registered Nurse (RN) indicated CNAs were responsible for fingernail care and stated nail care should be provided during shower days. The RN acknowledged long nails could pose a risk for digging into skin causing a wound for a resident with hand contractures.On 08/21/2025 at 3:31 PM, the Assistant Director of Nursing (ADON) inspected the hands of R12 and confirmed fingernails were long and could use trimming. The ADON indicated nursing, and CNAs should be providing routine nail care for vulnerable residents. On 08/22/2025 at 11:05 AM, the Infection Preventionist (IP) indicated nail care for residents was important for proper hygiene. Long nails could harbor microorganisms and pose an infection risk.The facility policy titled Nail Care adopted 05/01/2024, documented it was the policy of the facility to promote cleanliness, safety, and neat appearance of our residents.

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

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a physician order for Pressure Relief Ankle Foot Orthosis (PROFO - a specialized medical device used to relieve pressure and support the ankle and foot) boots were implemented as ordered for 2 of 40 sampled residents (Resident 10 and 9). The deficient practice had the potential for not limiting the progression of contractures of limited mobility residents and heel protection. Findings include: 1) Resident 10 (R10) was admitted on [DATE], with diagnoses including cerebral infarction and dependence on a respirator.2) Resident 9 (R9) was admitted on [DATE], with diagnoses including anoxic brain damage and dependence on a respirator.A review of the medical record for R10 and R9 revealed a physician order dated 08/13/2025, for the residents to wear bilateral lower extremity (BLE) PRAFO boots as needed for contracture management, every shift.On 08/19/2025 at 10:58 AM, observed R10 and R9 were not wearing PRAFO boots. On 08/20/2025 at 3:31 PM, observed R10 and R9 were not wearing PRAFO boots.On 08/21/2025 at 9:31 AM, observed R10 and R9 were not wearing PRAFO boots.On 08/21/2025 at 10:33 AM, observed R10 and R9 were not wearing PRAFO boots. On 08/21/2025 at 12:46 PM, observed R10 and R9 were not wearing PRAFO boots. On 08/22/2025 at 9:38 AM, observed R10 and R9 were not wearing PRAFO boots. On 08/21/2025 at 11:25 AM, the Director of Rehabilitation indicated PRAFO boots were typically applied daily or as tolerated. The boots were intended to prevent heel ulcers and foot drop. PRAFO boots application was handled by nursing staff and the rehabilitation department would educate nursing if needed with the application. The PRAFO boots were entered in the medical record as a physician order.On 08/21/2025 at 12:43 PM, a physical therapist (PT) indicated PRAFO boots were to keep alignment of the lower extremity and for the device to attain its purpose the application had to be daily.On 08/22/2025 at 9:10 AM, a certified Nursing aide (CNA) indicated PRAFO boots could be applied by both CNA and nurses. Most of the time the resident would request the boots to be put on, or the nurse would inform the CNA to ensure the boots were applied.On 08/22/2025 at 9:16 AM, a registered nurse (RN), indicated orders for PRAFO boots were transcribed onto the medication administration record (MAR) and nursing would then sign off the boots were applied as ordered. The RN indicated nursing, or CNAs could apply the boots.On 08/22/2025 at 9:37 AM, an RN reviewed the R10's and R9's MAR and confirmed the licensed nurse did not sign off the PRAFO boots were applied as ordered. The RN indicated entry of the PRAFO boots application orders in the MAR usually served as a reminder to nursing to assure the application of the device. On 08/22/2025 at 12:30 PM, the assistant director of nursing (ADON) reviewed R10's and R9's medical record and confirmed no documentation for application of the PRAFO boots were present. The ADON acknowledged the PRAFO boots should have been ordered as tolerated and not written as needed because a resident with lower extremity contractures would need the positioning device to prevent the progression of contractures. ADON indicated the orders should have been visible on the MAR to ensure its application.On 08/22/2025 at 2:30 PM, the director of nursing (DON) indicated the facility would follow a physician order for managing a resident's splint or positioning device. The DON reviewed R10's and R9's orders/ MAR and confirmed the physician order was not transcribed to the MAR.

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure a physician order for monthly urinary catheter change was completed for 1 of 40 sampled residents (Resident 12). The deficient practice had the potential for a resident to develop a urinary tract infection.Findings include: Resident 12 (R12) was admitted on [DATE], with diagnoses including urinary tract infection and infection/inflammation reaction due to other urinary catheter.On 08/19/2025 at 10:15 AM, R12 was observed in bed with a urinary tubing and collection bag hanging on the side of the bed.A Physician Order dated 05/01/2025, documented change indwelling Foley catheter or suprapubic catheter every 30 days on the 1st day of the month. One time a day starting on the 1st and ending on the 1st every month for Foley catheter care/maintenance. May change Foley catheter or suprapubic catheter if not contraindicated.The Comprehensive Care Plan revised 08/07/2025, documented the resident utilized an indwelling catheter and was at risk for trauma and infection and other complications of indwelling catheter use related to obstructive uropathy.R12's Medication Administration Record (MAR) lacked documented evidence that R12's urinary catheter was changed for the month of June and July of 2025.On 08/22/2025 at 9:16 AM, a Registered Nurse (RN) indicated an order to change a urinary catheter was transcribed to the MAR. The order was signed off by the nurse to signify the change had been completed. If the urinary catheter change was not completed, the nurse should notify the physician and document in the progress note as to why the change was not performed.On 08/22/2025 at 9:37 AM, an RN reviewed R12's MAR and confirmed the June and July order to change the urinary catheter were not signed off as completed. The RN indicated the nurse assigned should have documented in the progress notes. On 08/22/2025 at 12:30 PM, the Assistant Director of Nursing (ADON) reviewed R12's medical record and confirmed the June and July urinary catheter change was not signed off as completed. ADON was not able to provide documented evidence from nursing as to why the urinary catheter change was not completed as ordered. The ADON indicated if a resident had refused or for any reason the catheter was not changed the nurse should have entered a progress note.On 08/22/2025 at 2:30 PM, the Director of Nursing (DON) indicated the facility would follow the physician order for managing a urinary catheter. The DON reviewed R12's orders/ MAR and confirmed the entered order for the catheter change was not signed off as completed.

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a physician order was obtained for a Peripherally Inserted Central Catheter (PICC - a long, flexible tube inserted into a vein in the upper arm and threaded to a large vein in the chest near the heart) line and heparin lock (Heplock - a small, flexible tube inserted into a vein to maintain access for intermittent intravenous (IV) infusions) care, maintenance, and the dressing change per facility standards for 1 of 40 sampled residents (Resident 1). The deficient practice had a potential for placing a resident at risk for IV insertion site infections.Findings Include: Resident 1 (R1) was re-admitted on [DATE], with diagnoses including urinary tract infection and chronic respiratory failure.On 08/19/2025 at 10:00 AM, R1 was observed with two IV lines. A right upper arm IV access with two ports and a left mid arm IV access with one port. The medical record lacked documented evidence that a physician order was obtained for the care and maintenance of the IV accesses. On 08/20/2025 at 4:08 PM, both IV lines were present. The left arm heplock was not dated and the right arm PICC line had a dressing date of 08/03/2025. On 08/20/2025 at 4:25 PM, a Licensed Practical Nursed caring for R1 confirmed the presence of the 2 IV lines and verified from the electronic medical records (EMR) the lack of physician orders for both IV lines. The nurse confirmed the PICC line dressing was dated 08/03/2025 and should have been replaced when the resident was readmitted to the facility. The nurse indicated orders to maintain the IV accesses should have been initiated upon return from the hospital. On 08/22/2025 at 2:30 PM, the Director of Nursing (DON) indicated the facility would follow physician orders when managing IV access. The DON reviewed R1's orders and confirmed the entered orders for the IV access were dated 08/20/2025. The DON agreed that the orders should have been placed once the IV access was identified during the readmission nursing assessment to ensure proper management of the IV lines.

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and document review, the facility failed to provide medication for glaucoma (abnormal high pressure in the eye) as ordered by a physician for 1 of 40 sampled resident (Resident 185). The deficient practice could result in poor control of glaucoma and potential loss of vision. Findings include: The facility policy titled Medications, Provision of Routine or Emergency, indicated the facility provided medications to meet the needs of each resident. The policy indicated that prescribed medications were administered in a timely manner. Resident 185 (R185) was admitted on [DATE] with diagnoses including abscess of the liver. The resident was responsible for self and making medical decisions. The Minimum Data Set (MDS) assessment dated [DATE] indicated the resident had good memory function. On 08/22/2025, in the morning, R185 verbalized routine home medications included a prescription eye drop to each eye daily at bedtime to control glaucoma. R185 verbalized requesting the facility to furnish the prescription eye drop. R185 reported the facility staff verbalized they would order the prescription eye drop. R185 reported to date not having received the eye drop. R185 expressed a concern about being at risk of visual loss if the medication was not used consistently. A Physician Order dated 08/08/2025 indicated Bimatoprost Ophthalmic Solution 0.01 %, instill 1 drop in both eyes at bedtime for increased ocular pressure.On 08/22/2025 8:39 AM, the order audit report indicated the medication had been ordered on 08/08/2025 and then reordered on 08/13/2025. On 08/22/2025 the medication was listed as on order. The audit lacked documented evidence that the medication had been delivered.On 08/22/2025 in the morning, the Assistant Director of Nursing (ADON) was unable to locate the Bimatoprost eye drop on the unit. The ADON verbalized staff had attempted to order the medication, but it had not been delivered. The ADON spoke to a pharmacist who verbalized the medication request had not been filled as a prescription was needed and had not been provided. The ADON verbalized 14 days had elapsed since the order was received on 08/08/2025 until today, 08/22/2025. The ADON verbalized that the lack of the medication should have been addressed by nursing staff within a day or two after receiving the order. ADON did not know why nursing staff did not call the pharmacy to clarify what was needed to obtain the medication before now.On 08/22/2025, at 11:05 AM, the Director of Nursing (DON) verified the medication had been ordered by the physician on 08/08/2025, but the facility had not obtained the medication. The DON reported that the Bimatoprost eye drop was used to prevent raised intraocular pressure, which could damage the retina of the eye. The DON verbalized it was important to give the Bimatoprost consistently.

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and document review, the facility failed to ensure 1) enhanced barrier precaution (EBP - a set of infection control practices designed to reduce the spread of multidrug-resistant organisms (MDROs) in nursing homes) was maintained during care for 1 of 40 sampled residents (Resident 1), and 2) provisions in the water management program was implemented. The deficient practice had potential for microbial infection to develop and spread within the facility.Findings Include: 1) Resident 1(R1) was re-admitted on [DATE], with diagnoses including urinary tract infection and pneumonia gram negative bacteria. R1's physician's order dated 08/17/2025, documented Enhance Barrier Precaution: Tracheostomy, ventilator, Gastrostomy tube and indwelling foley catheter. On 08/20/2025 at 4:05 PM, observed a certified nursing aide (CNA) emptying R1's Foley catheter bag with gloves donned. The CNA was not wearing a gown. On 08/20/2025 at 4:18 PM, the CNA indicated a gown should have been worn when emptying a Foley catheter bag for a resident on EBP. The CNA acknowledged the risk of splatters when emptying a urine bag and potential cross contamination between residents and other staff. On 08/22/2025 at 11:05 AM, the Infection Preventionist (IP) indicated staff were educated on transmission-based precautions (TBP) and the appropriate personal protective equipment (PPE) to be used during care activities. The IP indicated TBP signage should be followed. The IP acknowledged not following TBP poses a risk of cross contamination for the resident population and other staff members. The facility policy titled TBP (Isolation), Enhanced Barrier Precautions adopted 05/01/2024, documented residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDRO. The use of gowns and gloves for high-contact resident care activities is indicated. 2) On 8/21/2025, the Administrator indicated the Maintenance Director was responsible for the water management plan. The Maintenance Director explained the facility had a water management plan but did not think the plan addressed the prevention of Legionella, however, the facility intended to include Legionella in the plan next month. On 8/21/2025, the Infection Preventionist was not familiar with the facility's water management plan. The facility, Water Management Program for Prevention of Legionella Growth, revised 6/27/2023, was provided on 8/22/2025. The resources cited in the facility's Water Management Program (WMP) was the Center for Disease Control (CDC) Toolkit Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings, a nationally accepted standard. However, many components of this standard were not included in the facility's WMP. The WMP did not explain the water flow in the building in both text and diagram. The WMP listed areas of potential risk but included risks that were not applicable to the facility. These included hot tubs and cooling towers. The list of areas of potential risk included risks that were applicable to the building but did not define the location or number of the risks. These included showerheads, ice (continued on next page)

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	machines, water heaters and eyewash stations. The WMP stated the preventative maintenance included verification and documentation at least once weekly to ensure the domestic hot water boiler/storage tanks were set between 140-160 degrees Fahrenheit, and the temperature of water entering the circulating system at the mixing valve set at 120 degrees Fahrenheit or above. The facility failed to provide documentation the temperature measures were completed. The WMP stated the preventative maintenance included ice machines inspections for leaks and contamination at least monthly. The WMP did not state the number and location for the ice machines. During a telephonic interview on 8/22/2025 at 12:20 PM, the Maintenance Director explained there were five ice machines, and a vendor cleaned the ice machines monthly. The facility failed to provide documentation, the ice machines were cleaned monthly. The WMP stated the preventative maintenance included weekly sanitizing of medical devices such as continuous positive airway pressure (CPAP), hydrotherapy, etc. The Administrator indicated on 8/21/2025 that the facility had 25 ventilator-dependent residents. The facility failed to provide documentation ventilator maintenance and cleaning was completed weekly. The WMP stated the elements of the water management program should be reviewed at least once per year. The WMP indicated the effective date was 6/30/2017, and the revisions occurred on 12/28/2017, 7/19/2019, and 6/27/2023. There was no evidence provided to indicate the WMP had been reviewed within the past year.

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. **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 (continued on next page)

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	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 a wiring issue in one of six hallways on the first floor and one of six hallways on the second floor. The wiring issue affected 12 rooms in 2300 Hall and seven rooms in 1300 Hall. 2300 Hall was closed at this time to allow for the air conditioning repairs to be completed without resident disruption. The air conditioning in rooms 1301 to 1305 continued to function and the residents remained in the rooms, while the remainder of 1300 hall was closed.- On 07/12/2025. all remaining rooms in 1300 Hall were closed to allow for HVAC wiring repairs to be completed.- One of six hallways on the first floor and one of six hallways on the second floor had remained closed since 07/12/2025 while HVAC repairs were being completed.During the onsite investigation on 08/19/2025 through 08/22/2025, the facility's correction of the past non-compliance related to the air conditioning not in good working condition occurred as evidenced by:- A tour of the facility revealed the resident rooms were not visibly hot. The room temperature ranged from 70.2 degrees Fahrenheit to79.0 degrees Fahrenheit. There were three portable air conditioning units on the first floor and two portable air conditioning units on the second floor.- The affected halls (1300 Hall and 2300 Hall) were closed.- During the onsite investigation, there were no residents who complained about the hot room temperature.- A CNA confirmed the resident room temperatures were okay now and the CNA had not received any complaints from the residents about the hot room temperature.- On 08/21/2025 at 1:57 PM, during the resident council meeting, the residents had no complaints about the room temperatures. Complaint 2289515